

**'HEALTHY SCHOOLS' AND CHILDHOOD OBESITY: PROVISION AND  
PERSPECTIVES WITHIN AN EXTENDED SERVICES CLUSTER ON  
PSYCHOSOCIAL OUTCOMES FOR CHILDREN AND YOUNG PEOPLE WHO  
ARE OVERWEIGHT OR OBESE: VOLUME ONE AND TWO (APPENDICES)**

**VOLUME ONE**

**By**

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**A thesis submitted to  
The University of Birmingham  
for the degree of  
DOCTOR OF EDUCATIONAL PSYCHOLOGY**

**School of Education  
College of Social Sciences  
The University of Birmingham  
August 2010**

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# **ABSTRACT**

Research, policy and media discourses highlight risk of negative physical and non-physical outcomes for overweight/obese children compared with their non-overweight/obese peers.

The study's aim was to explore whether psychosocial correlates were being considered and informing policy and practice with regard to the 'National Healthy Schools Programme' (NHSP) within a cluster of schools, and with their community and strategic partners. Stakeholders' perspectives including those of pupils were sought to illuminate whether, as a result of the NHSP, the potential risk of unintended harm was recognised and addressed.

The research was conceptualized as an exploratory case study that primarily entailed the use of qualitative research methods for data collection and analysis. The findings of the study highlighted dominant socio-cultural practices that reinforce the 'thin ideal' and some of the risk potentiation and compensatory factors that could impact on outcomes for children. The dominance of the 'physical' themes of the NHSP reflected weakness in the operational delivery of a multidimensional rather than a fully integrated 'holistic' model of health and well-being.

Recommendations for future research and practice include the future positioning of educational psychology practice and promoting meaningful consultation processes that ensure children's perspectives are heard and listened to.

# DEDICATION

Isaiah 20:2

Forever faithful and gracious

# ACKNOWLEDGEMENTS

I would like to express my deepest respect and appreciation to Sue Morris and Sarah Parsons, University of Birmingham, for their exemplary and sagacious supervision. It was an honour and real pleasure to be party to your individual and collaborative support, advice, and generosity during my research endeavours.

I have the privilege of many dear friends and family who have supported me through this journey and much thanks to you all for your kind forbearance, thoughts and actions. Some of you have had roles that need a special mention. Denny for your prayers, Jules, much gratitude for your help with the proof reading. Aydan, for your empathic ear and support as a result of your own researcher story. Del for being that much needed buoy at work that helped me keep the plates spinning. Neil and Paulette, your stalwart confidence in me, pragmatic words and encouragement helped me to survive the most challenging time.

I want to give special thanks to my father Lloyd and my mother Pearl. Your attitudes and values about education, informed by your own disadvantaged experiences have been a guiding force to me from childhood and subsequent lifelong learning endeavours. Dad, your beacon of faith and pride from all those thousands of miles away kept the light switched on when I needed it.

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## GLOSSARY OF TERMS (ABBREVIATIONS)

<b>ABC</b>	Anti-Bullying Coordinator
<b>ARG</b>	Advisory Reference Group
<b>BMI</b>	Body Mass Index
<b>CAMHS</b>	Child and Adolescent Mental Health Services
<b>CC1</b>	Children's Centre 1 (Healthy Settings Coordinator)
<b>CINAHL</b>	The Cumulative Index to Nursing and Allied Health Literature
<b>CRB</b>	Criminal Records Bureau
<b>CSCM</b>	Community Spots Centre Manager
<b>CSF</b>	Contact Summary Form
<b>CYP</b>	Children and Young People
<b>DCFS</b>	Department of Children Family and Schools
<b>DfE</b>	Department for Education
<b>DfEE</b>	Department for Education and Employment
<b>DOH</b>	Department of Health
<b>DSF</b>	Document Summary Form
<b>ECM</b>	Every Child Matters
<b>EHWB</b>	Emotional Health and Well-Being
<b>EP</b>	Educational Psychologist
<b>EPS</b>	Educational Psychology Service
<b>ESC</b>	Extended Services Cluster
<b>ESCC</b>	Extended Services Cluster Coordinator
<b>ET</b>	Ecological Transactional
<b>ETS</b>	Ecological Transactional System
<b>HESHSC</b>	Health Education Service Healthy Schools Coordinator
<b>HSEM</b>	Healthy Schools Enhancement Model

<b>LA</b>	Local Authority
<b>NAS</b>	National Advisory Service
<b>NCMP</b>	National Child Measurement Programme
<b>NHS</b>	National Health Service
<b>NHSP</b>	National Healthy Schools Programme
<b>NHSS</b>	National Healthy Schools Standard
<b>NICE</b>	National Institute for Health and Clinical Excellence
<b>NSPCC</b>	National Society for the Prevention of Cruelty to Children
<b>PARG</b>	Primary Advisory Reference Group
<b>PCMG</b>	Parent/Carer Meeting Group
<b>PCT</b>	Primary Care Trust
<b>PEA</b>	Physical Education Adviser
<b>PFG</b>	Primary Focus Group
<b>PHSE</b>	Personal Health Social Education
<b>PS1</b>	Primary School 1 (Healthy Schools Coordinator)
<b>PS2</b>	Primary School 2
<b>SARG</b>	Secondary Advisory Reference Group
<b>SEAL</b>	Social and Emotional Aspects of Learning
<b>SES</b>	Socio-Economic Status
<b>SFGB</b>	Secondary Focus Group Boys
<b>SFGG</b>	Secondary Focus Group Girls
<b>SIGN</b>	Scottish Intercollegiate Guidelines Network
<b>SS1</b>	Secondary School 1 (Healthy Schools Coordinator)
<b>WHO</b>	World Health Organisation
<b>UK</b>	United Kingdom
<b>UN</b>	United Nations
<b>US</b>	United States of America

## **CHAPTER 1: INTRODUCTION**

**“Before Governments and other agencies leap into actions that they assume to be beneficial in the battle against obesity, we must remember to employ one of the most important principles of modern medicine and prevention science, ‘First do no harm’”.**

**[O’ Dea 2005 p259]**

### **1.1 Thesis structure**

The thesis is presented in two volumes to facilitate access and cross referencing within and between the main body of the thesis (volume one) and the appendices and references (volume two). The overview for volume one is set out in section 1.7 below, following a contextual foreword about the study.

### **1.2 Background**

The aim of this research study was to explore how psychosocial correlates of childhood obesity were being considered and informing policy and practice within interventions aiming to prevent and manage childhood obesity. The primary focus was to make sense of the impact of a national school-based health promotion initiative, the National Healthy Schools Programme (NHSP), in minimising the potential risk of creating or exacerbating negative psychosocial outcomes which might arise as a result of the NHSP’s interventions.

The study’s objective was to explore and consider the perspectives of key stakeholders within an identified ecological context, comprised of a cluster of schools, and their community and strategic partners with regard to their

endeavours with the NHSP. An important feature of the study was to ensure the inclusion of children and young people's voices, to inform reflections as to whether the well-intentioned actions of the NHSP and the approaches adopted by service providers may in fact, contribute to the marginalisation and/or stigmatisation of children and young people whose weight status is perceived as a cause of concern (Curtis, 2008).

Over sixty years ago, Bruch described obese children as "fundamentally unhappy and maladjusted" (1941 p467). Bruch's scrutiny was focused on the reported dysfunctional interpersonal relationships between parents and children observed in psychiatric settings. At the present time, children and young people identified or perceived as overweight/obese are subject to a much wider public scrutiny and surveillance. Their weight status socially, politically, and medically is considered undesirable and subject to international, national and local foci for prevention and management action (World Health Organisation (WHO), 2000; Department of Health (DOH), 2004a). Psychosocial correlates that contribute to, or arise from, childhood obesity are now placed within a wider socio-cultural ecological systemic context of complex transactional relationships (Augustyn, 2006).

The identified psychosocial correlates of childhood obesity include increased risk for peer difficulties, negative body image, disordered eating, lower social competence and self-esteem, as well as higher rates of depressive symptomatology, (Neumark-Stztainer et al., 2007; Erickson et al., 2000; Strauss, 2000). However questions have been raised about the evidence available that

positions obese/overweight children as “fed up and friendless” at home, at school, in their local community and in society at large (Hill, 2005 p280).

The wider public interest in obesity is a result of its status as a global epidemic affecting all age groups (WHO, 2000). During the past two decades the reported rising prevalence of childhood obesity has led to an avalanche of research reports, government papers and policies, health initiatives, books, journals, radio and television programmes alongside newspaper reporting making comment and seeking to address the growing ‘problem’ of childhood obesity (Evans et al., 2008). Heavy media coverage can be seen as an indicator of the significance of a research topic as a current social problem (Bilken and Casella, 2007). Examples of recent media headlines are given in Table 1.1 overleaf.

As argued by Burrows and Wright (2007) such media sources regularly represent children as either overweight now or ‘at risk’ of becoming that way and the reasons are inexorably put forward as being straightforwardly true. Evans (2010) agrees with their argument that such alarmist discourses also pervade policy reports on obesity and shape policy action.

In the past, the emphasis for action was reducing the risk of negative physical outcomes for children and young people. However, more recently, psychosocial outcomes and the mediating role of weight bias/stigma have come under increasing attention (National Institute for Clinical Excellence (NICE), 2006; Puhl and Latner, 2007).



**Table 1.1 A selection of media headlines (UK national newspapers) on childhood obesity 2007-2010**

Obesity Stigma: How fat kids are shunned at school  
(*Daily Mail*, May 5, 2010)

Fat-fighting classes for school pupils aged just five  
(*The Express*, February 4, 2009)

Fat map reveals 1 in 10 children is obese when starting school  
(*The Times*, June 24, 2008)

Britain's first live-in school for fat pupils: Overweight children will learn dieting tips as well as the three Rs at a new private boarding facility  
(*The Observer*, July 27, 2008)

Schools to warn parents their children are overweight in bid to cut obesity rate  
(*The Independent*, August 5, 2008)

Obese children 'risk being stigmatised'  
(*The Daily Telegraph*, July 18, 2007)

Take fat children into care  
(*Daily Mail*, November 13, 2007)

Despite the limited UK-based research, and the inconsistencies and uncertainties arising from the current evidence base, there appears to be some consensus that obesity is a potential risk factor with regard to children's psychological and emotional well-being, and that vigilance for potential difficulties is a responsible approach to take (Lee and Shapiro, 2003).

In health contexts the terms obese and overweight are distinguished and clinically defined using a measure called the Body Mass Index (BMI), a weight to height ratio ( $\text{kg}/\text{m}^2$ ) (Cole and Roland-Cahera, 2002)<sup>3</sup>. Research has repeated this differentiation; however, this is not universal in the literature and the terms are used interchangeably (Puhl and Latner, 2007; Brownell, 2005; Evans, 2004). In both the research and public arenas the medical terms 'obese' and 'overweight' appear to have become commonly used euphemisms to replace the more negatively connotated word 'fat' (Allon, 1982). In fact the Department of Health advises use of the term overweight rather than obese with children (DOH, 2006). Wadden and Didie (2003), as a result of research on a clinical population of adults, found participants rated terms such as fatness and obesity as the most undesirable, and reported preference for non-judgemental terms as weight. Brownell (2005) has argued that the term 'fat' is in vogue with some authors because of negative connotations attached to the word obese (as a condition). Use of the term also attempts to remove the stigma from the word fat by using it in an open way. For the purposes of my research terms such as fat, overweight, and obese are used interchangeably. Weight bias/stigma, meanwhile, refers to negative weight-related attitudes and beliefs that are displayed by stereotyping, rejection, and prejudice towards children and adults because they are overweight or obese (Brownell, 2005).

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<sup>3</sup> For adults a BMI between 25 and 29.9 is considered overweight and a BMI of 30 or higher is considered obese. The BMI measurement in children and young people is related to the UK 1990 BMI growth reference charts. The DOH has recommended that the 98th and 91st centiles define obesity and overweight, respectively.

Current policy guidance has identified schools as key settings to address the significant public health challenge of childhood obesity (Cross Government Obesity Unit, 2008). National and local governments perceive the National Healthy Schools Programme (NHSP) as the primary vehicle for schools working with strategic and community partners to respond to this health challenge (DOH, 2007). The NHSP is aimed at raising awareness and standards of health-related practice in schools and increasing the health-related knowledge, skills and behaviour of pupils (Barnard et al., 2009). Some schools may be addressing childhood obesity within their role as an Extended School or as a partner school within an Extended Services Cluster (ESC) (DCSF, 2007).

Schools have been cautioned in statutory guidance to make sure that health promotion and obesity prevention programmes do not deny children's rights to protection and privacy (NICE, 2006). O'Dea (2005) advocates a 'First do no harm' principle for schools planning and implementing health promotion initiatives. It is not clear if school-based health promotion initiatives such as the NHSP have (either positive or negative) side effects on children's psychosocial well-being. Some commentators (e.g. Chadwick and Crocker, 2005) have voiced concerns that the unintended toxic effects could undermine positive psychological benefits of interventions. Curtis' (2008) qualitative study with young people identified as obese has highlighted that the whole school approach of the NHSP may fail adequately to address the experiences of marginalised and vulnerable groups. Evans (2003, p98) highlighted the danger of "new, invidious social and ability hierarchies" of success defined in terms of body shape, size and weight that may

emerge around health and physical education developments in schools. I considered the question as to how far schools' and Extended Services Clusters' actions on these issues are informed by an understanding of relevant research.

As an Educational Psychologist (EP), I am aware that EPs are in a position to offer an applied psychological perspective to schools and communities on psychological well-being and mental health initiatives within inclusive frameworks (Farrell et al., 2006; Rosenthal 2001; National Health Service/Health Advisory Service, NHS/NAS 1995). However, with one exception (Bromfield, 2009<sup>4</sup>), there is no evidence of published interest or research by EPs in relation to working with schools and settings to promote positive psychosocial outcomes for children and young people who are overweight/obese .

My professional interest in the issue of childhood obesity has been cultivated by casework and consultation experiences in schools and community settings. Those experiences were key drivers that gave momentum to this research study. However I also acknowledge that my own experiences as fat child, adolescent and adult have also been important influences in my professional interest and response in the debate which should not be made invisible or considered insignificant as a variable within the research study.

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<sup>4</sup> See Appendix 1.1 - Bromfield, P.V. (2009) Childhood obesity: psychosocial outcomes and the role of weight bias and stigma **Educational Psychology in Practice**, 25 (3): 193–209. This peer review article is an earlier and shorter version of the following literature review chapter.

A starting point for the study was the submission of a research proposal (see Appendix 1.2 for an edited copy), through which I provided an outline of the purpose (focus) of the study and the original research questions. The importance of the research was also justified. Aspects of the initial proposal were subject to minor revisions in the early stages of the research and the final formulations are summarised below.

### **1.3 Purposes of the study**

The purposes of this study were to explore:

- the current evidence base on the psychosocial outcomes for children and young people who are overweight/obese with particular reference to the five outcomes of the Every Child Matters agenda – being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic wellbeing (DfES, 2004);
- the current evidence base on how the phenomenon of ‘weight bias/stigma’ relates to the causes, nature and consequences of these outcomes;
- within an extended services cluster, the rationale and nature of approaches concerned with prevention and management of obesity, and consider how these approaches alongside other indirect initiatives (e.g. anti-bullying policies), serve to address potential negative psychosocial outcomes; and

- the views of children and young people regarding the psychosocial experiences for young individuals who are overweight/ obese and the universal and targeted health promotion provision in place, particularly within their school settings.

## **1.4 The research questions**

There was an expectation that the subsequent literature review would lead to more clarification to the research questions listed here below:

1. Can the evidence base on the psychosocial correlates of childhood obesity be mapped onto the ECM outcomes as well as highlight significant gaps in research?
2. Does the evidence base on the role of weight bias/stigma provide a valid account of its mediating or moderating role in the causes and/or consequences of obesity?
3. What are the approaches that are being promoted by partners, particularly schools, within an Extended Services Cluster regarding the prevention and management of child and adolescent obesity?
4. Do the shared and differential perspectives on policy and practice indicate how such initiatives serve to address and prevent potential negative psychosocial outcomes?

5. What are the experiences and views of children and young people on childhood and adolescent obesity and on the role and impact of initiatives such as the NHSP which is considered a key vehicle for schools to prevent and reduce childhood obesity?

## **1.5 Importance of the study**

I have identified four potential outcomes to justify the utility of my research:

- to provide a critical review of the literature and published research evidence in order to inform the practice of educational psychologists (EPs) who, to date as a profession, appear to have minimal engagement with the subject of childhood obesity;
- enabling the voices of children and young people to be heard on this topic;
- to add to the relatively small evidence base of UK studies on the nature and implications of psychosocial correlates of obesity in childhood; and
- to enable the multi-agency partners within an extended services cluster and individual schools within that community to consider the nature and the content of any framework through which they will choose to evaluate the impact of initiatives on childhood and adolescent obesity, so that they are primed to anticipate, contain and/or monitor risks of unintended negative psychosocial sequelae.

## **1.6 Nature of the study**

The research design was informed by a pragmatic paradigm that primarily entailed the use of qualitative research methods for data collection and analysis. The research was conceptualized as an exploratory case study of an extended services cluster in a large metropolitan local authority.

## **1.7 Overview of the thesis**

For this main volume of the thesis, I have adopted with some variation of the standard and traditional chapter template of *Introduction, Literature Review, Methodology, Analysis, Discussion, and Conclusion*. Stapleton and Taylor (2003 p5) argue, “In succumbing to the structural template of positivism, novice qualitative writers are in danger of creating distorted portrayals of their inquiries as timeless, lacking in contingency and without an emergent nature”.

The linear structure could imply that:

- the literature review was conducted during the initial stages of the research design,
- the research design was fully formed prior to data ‘collection’, and
- the ensuing results of the study were uncontaminated by the subjectivity of the (value-neutral and unbiased) scientific researcher.



However I aim to ensure the framework allows an accurate account by the use of a narrative and reflexive stance.

The thesis is divided into nine chapters. Following this first chapter, Chapter 2 provides a systematic and comprehensive review of relevant policies, research and theoretical literature. An overview is given of the literature review's role within the study as well as the plan used to identify sources and conduct the review. The chapter sets out a synthesis of the critical analysis of research, policy and media discourses that have highlighted negative physical and non-physical outcomes for overweight/obese children and adolescents compared with their non-overweight/obese peers. The research findings that have positioned this 'vulnerable' group are reviewed with particular reference to the desired outcomes of the 'Every Child Matters' agenda (DfES, 2004). The mediating role of weight bias/stigma is also explored. The relevance of these issues with regard to educational psychology service delivery priorities is also considered. In particular, consideration is given to the question of how educational psychologists position themselves in relation to challenging some of the identified discourses, alongside providing support for children, families, schools, and other service providers for whom the phenomenon of childhood obesity is a concern.

Chapters 3, 4 and 5 provide a serial narrative of the methodological developments within the study, summarising the key process that impacted on the espoused and final enacted design. There will be evidence of the emergence of the research design, the shifting nature of the methodology, the continuous reviewing of

literature to establish significance of emergent issues, and the progressive subjectivity of the researcher (Denzin and Lincoln, 2005). Chapters 3 and 4 will also be the main vehicles to share reflections regarding the ethical considerations and challenges arising from the study.

The last methodology Chapter (Part 3, Chapter 5) provides an introduction to the chosen methods of analysis. Sideal (1998) argues that there is a common simple foundation to the complex and rigorous practices of qualitative data analysis. This involves a process of 'noticing, collecting and thinking about interesting things'. One aim in the chapter is to show how the chosen thematic analysis methods (Braun and Clark, 2006; King, 1998; 2004) provided a hybrid framework for this to happen.

The nature and outcomes of the adopted thematic analysis on the data are further explored and summarised in Chapter 6, the analysis chapter, which concludes with the final key themes that I abstracted from the data corpus.

Chapter 7, the first of two discussion chapters should be seen as the final stage of analysis of the data where the key themes are examined in greater depth. One objective of the chapter is to see whether my use of an ecological-transactional model as a conceptual framework to represent and consider the findings from the data corpus was realized. The second discussion chapter, Chapter 8 focuses on the key methodological considerations that arose from the study.

Chapter 9, the concluding chapter considers whether the purposes of the study and the research questions have been achieved in light of the main findings of the study. Recommendations for future research and practice are presented

Overall, the priority of this research is not theory generation or testing but to provide a means for a community to tell its story about its approach to childhood obesity and provide a voice to children and young people. To summarise Sim (1998) as quoted in Robson (2002), data gained from a particular study may provide theoretical insights *and recommendations for actions*, which possess a sufficient degree of generality or universality to allow their projection to other contexts and situations.

## CHAPTER 2: LITERATURE REVIEW

**“Viewed sympathetically, the current state of knowledge about overweight and obesity could be seen as an incomplete jigsaw for which the pieces are gradually being found and fitted together.... *(Unsympathetically)* our scientific knowledge about overweight and obesity is not so much incomplete as confused and replete with flawed and misleading assumptions”.**

**[Gard and Wright 2005 p3]**

### **2.1 The role of the literature review**

Childhood obesity as a topic has generated expansive commentary and research focused on the historical, biological, medical, social, economic, environmental and psychological facets of this complex phenomenon. My research objective in exploring how an extended services cluster was taking into account psychosocial correlates of childhood obesity, primarily through its schools’ participation in the National Healthy Schools Programme (NHSP) initiative, informed the scope and approach in specifying, identifying and synthesising relevant sources in the literature.

The process of researching and writing the literature review was not only about identifying gaps and clarifying research questions; it also served as a key influence in informing and shaping the methodology of my research as will be shown in the following methodology chapters. An ongoing theme in my reflections on the literature was acknowledgment that the reproduction of obesity knowledge is situated in wider social and cultural contexts which positions thin as good and

fat as bad (Campos, 2004). There is a small but growing body of work that questions dominant assumptions about the causes and consequences of obesity as well as its 'crisis' manifestation (Monaghan, 2005). Obesity is largely positioned as a taken-for-granted problem, with an emphasis on solutions. Gard and Wright (2005) argue that this distracts attention from challenges to the social, political, cultural and moral construction of fatness as a massive health problem. Acknowledging and understanding these contexts is central to the development of critical approaches (Evans, 2006). Consequently what follows shows that the research agenda is dominated by a 'privileged' rather than a more knowledgeable position within a range of voices offering perspectives (Kovach, 2005).

## **2.2 Sources of information and search plan**

A range of publications formed appropriate sources evidencing the multiple discourses on childhood obesity. Journals, books, national/local government documents and media articles were used. My professional role as an educational psychologist (EP) also led to a particular interest in sources informed by disciplines in applied psychology. A search to identify relevant literature from sources was undertaken on computerised psychological, medical, social science, and education databases e.g. PsycINFO; CINAHL;. Initially the period from 1980-2009 was the search time frame, with research studies between 2000 and 2010 increasingly becoming a focus. The following keywords as combinations were used in searches: 'adolescent' 'appearance' 'bullying', 'child', 'childhood',

'children', 'emotional', 'fat', 'heavy', 'health' 'healthy schools', 'management' 'obese', 'obesity' 'overweight', 'prevention', 'psychological', 'psychologist', 'psychosocial', 'social', 'health promotion', 'well-being' 'weight bias', 'weight stigma', 'schools'. Other sources included reference lists of retrieved articles and books. Additional searches were conducted on the web sites of national and local governmental agencies.

A key objective for the search plan was to identify recent UK studies on childhood obesity and psychosocial correlates. Twenty-three studies between 1995 and 2009 were located and a summary of the key details of these references can be found in Table 2.1 overleaf. Alongside the findings of the studies, I was interested in the predominant themes with regard to the type, focus, sampling sources as well as the methods and research instruments used. The majority of the studies were cross-sectional in nature accessing both clinical and community based samples. A range of research methods and instruments were used including questionnaire surveys, interviews and focus groups. The majority of the studies seem to validate in part the outcomes of other international studies in particular from the US, that appear suggest that obese and overweight weight status defined primarily by BMI measures was correlate marker of varying significance to negative psychosocial correlates. These findings will be further discussed in the following section.

**Table2. 1: Published UK studies on the psychosocial correlates of childhood obesity 1995 – 2009**

Study	Type	Focus	Community / clinical/treatment sample	Methods and research instruments	Findings
1. McCollough et al., 2009	Cross-sectional	The aim of this study was to examine the relationship between obesity and self-esteem in children in relation to specific domains of their self-perception, and further to explore the extent to which this may vary by gender and economic circumstances	A total of 211 children aged 8–9 years drawn from both advantaged and disadvantaged areas of Belfast	Harter Self-Perception Profile for Children and measures of body mass index were obtained	Overweight, impoverished children had significantly reduced social acceptance and physical competence scores. Boys had significantly lower scores than girls in the behavioural conduct domain. Girls had significantly lower scores than boys for the athletic competence.
2. Curtis, 2008	Cross-sectional	The experiences of young people with obesity in secondary school: some implications for the healthy school agenda	Community sample 17-18 participants aged 10 -17. Drawn from a community based intervention programme	Focus groups and individual interviews	Despite the social inclusion agenda, activities prioritised within the programme may contribute to the marginalisation of young people with obesity and play an important part in the construction of undesirable young bodies.
3. Gray and Leyland, 2008	Cross-sectional	A associations between psychological distress and being overweight in adolescents, by sex, accounting for social, lifestyle and contextual factors	Community 635 male and 618 female adolescents (13–15 years)	Use of General Health Questionnaire data from 2 cross-sectional surveys. Height and weight measures taken by interviewers	Being overweight is associated with psychological distress in adolescent girls, but not boys. Effects are not mediated by social, lifestyle or contextual factors.
4. Sweeting, West and Young, 2008	Cross-sectional	The aim of this study is to report the prevalence of obesity and its association with SES, well-being and worries about weight among 15-year olds in 1987, 1999 and 2006	Height and weight data obtained from 15-year olds in 1987 (N = 503), 1999 (N = 2,145) and 2006 (N = 3,019), allowed categorisation of obesity (UK90 criteria)	Height and weight data obtained. SES was represented by parental occupational class and area deprivation; psychological wellbeing by the 12-item General Health Questionnaire (GHQ-12) and self-esteem; weight worries by 'a lot' of worry about weight	Between 1987 and 2006, prevalence of obesity among Scottish 15 year olds increased around 2.5 times. However, this increasing prevalence did not impact on the obesity-weight-worry relationship. While many obese adolescents appear unconcerned about their weight, a significant minority of the non-obese worry needlessly.

**Table2. 1 continued: Published UK studies on the psychosocial correlates of childhood obesity 1995 – 2009**

Study	Type	Focus	Community / clinical/treatment sample	Methods and research instruments	Findings
5. Griffiths and Page 2008	Qualitative cross-sectional study	The impact of weight-related victimization on peer relationships: The female adolescent perspective	Clinical sample of five obese female adolescents aged 12-17yrs	Multiple, semi-structured, in-depth interviews	Weight-related victimization experiences were common and their impact on peer relationships was complex.
6. Griffiths et al 2006	Quantitative – prospective cohort study - part of established longitudinal study	Obesity and Bullying	Community sample Population pre-adolescent	BMI measures via trained researchers Standard interview 'Bullying and Friendship Interview Schedule' by trained psychologists.	Obesity is predictive of bullying involvement for both boys and girls. Preadolescent obese boys and girls are more likely to be victims. Obese boys are likely to be bullies.
7. Murtagh et al 2006	Qualitative cross-sectional study	Physical and psychological levers and barriers to weight loss	Clinical – 20 participants (14 boys) aged 8-14	Open ended questions Individual Interviews and focus group sessions	Descriptions of social torment and exclusion as the main reasons for losing weight.
8. Penny and Haddock 2006	Cross-sectional	Anti-fat prejudice among children	Community  89 children aged 5-10 year old	Children looked at 24 matching pairs of a female and male character, where one is overweight and one is average-weight. And asked how much they would like to be friends with a particular individual using a four point rating scale.	Significant mere proximity effect for female targets and effect is present in children as young as five years of age.



**Table2. 1 continued: Published UK studies on the psychosocial correlates of childhood obesity 1995 – 2009**

Study	Type	Focus	Community / clinical/treatment sample	Methods and research instruments	Findings
9. Wardle et al 2006	Cross-sectional	Depression in adolescent obesity: cultural moderators of the association between obesity and depressive symptoms	Community  4320 children aged 11 and 1824 adolescents aged 14-15.	Students completed one of two measures of depressive symptoms (SDQ; CES-D) in school and were weighed and measured.	In community samples of adolescents, regardless of gender, SES or ethnicity, reports of depressive symptoms are not significantly higher in obese than normal-weight groups.
10. Wills et al 2006	Qualitative cross-sectional	Body Image Perception	Community Adolescent (selected mixed normal weight and overweight/obese sample)	Screening questionnaire BMI measure Interviews in home setting by one of the authors	BMI definitions too simplistic with regard to perceptions of overweight. Not all overweight obese CYP are bullied. Not all teenagers are striving for thinness.
11. Holt et al 2005	Qualitative cross-sectional study	Children's perceptions of attending a residential weight camp in the UK.	Clinical selected sample from weight camp participants .15 attendees (6 females) 10-15 years old	Semi-structured interviews 5 months after camp intervention	Pre-camp issues included goals and aspirations to reduce bullying, increase self esteem and make friends. Study did not focus on whether goals had been achieved just the positive elements of the camp experience.
12. Sweeting et al 2005	Quantitative – part of an established longitudinal study (see Sweeting and West 2001 below)	Psychological correlates of obesity – self reported well being, weight related concerns, self image, peer relationships and psychiatric disorders	Community Cohort of 2127 school pupils survey at age 11 and 15	School based survey conducted in exam type conditions. BMI Questionnaire and short interviews conducted by Nurses	Although overweight was fairly stable, there were shifts in an out of the obese category during adolescence. Obesity during this stage of life although strongly related to worries about putting on weight and self report dieting was associated with only small differences in psychological well- being.

**Table2. 1 continued: Published UK studies on the psychosocial correlates of childhood obesity 1995 – 2009**

Study	Type	Focus	Community / clinical/treatment sample	Methods and research instruments	Findings
13. Viner and Cole 2005	1970 British birth cohort longitudinal study	Assess adult socio-economic educational, social and psychological outcomes by using nationally representative data.	Community  Use 10 year old and 29-30 year old data	BMI, SES, BAS scales , parental BMI and occupation and mother education for 10 year old Computer interview or self report survey. Self reported BMI , occupational standards, annual net income, employment history, longstanding illness , mental health	Obesity limited to childhood has little impact on adult outcomes.
14. Sands and Wardle (2003)	Prospective cohort study	Internalization of Ideal Body Shapes in 9–12-Year-Old Girls Participants (n ¼ 356) were weighed and completed measures of body dissatisfaction, awareness and internalization of the thin ideal, and peer and maternal attitudes and behaviour. Exposure to relevant print media was also assessed.	356 girls age d 9–12 from fee-paying girls' schools in UK	Socio-cultural Attitudes Towards Appearance Questionnaire, Body Esteem Scale, Measures of Body Shape Perceptions and Preferences; Perception of Weight; Maternal and Peer Weight/Eating-Related Concerns and Behaviours ; and Media Exposure	Body dissatisfaction was associated with a higher body mass index, although it was not restricted to overweight girls.
15. Walker et al 2003	Qualitative cross-sectional study	Children's weight-loss camps: psychological benefit or jeopardy	Treatment 57 campers and 38 normal weight comparisons. Of the campers, 33 females and 24 males with a mean age of The comparison group comprised 19 females and 19 males with a mean age of 14 y, 4 months (range 12.1–15.9)	Weight and height Self Perception profile for children The Salience of Weight Related Issues Scale The Pictorial Figure Silhouette Scale	While obese adolescents had lower self-worth and greater body dissatisfaction relative to the comparison children at the start of the camp, the intervention improved their psychological state. Greater weight loss was associated with greater psychological improvement, indicating the value of the intervention and the relevance of psychological change in effective treatment.

**Table2. 1 continued: Published UK studies on the psychosocial correlates of childhood obesity 1995 – 2009**

<b>Study</b>	<b>Type</b>	<b>Focus</b>	<b>Community / clinical/treatment sample</b>	<b>Methods and research instruments</b>	<b>Findings</b>
16. Burrows and Cooper 2002	Cross-sectional	Possible risk factors in the development of eating disorders in overweight pre-adolescent girls	Community 18 overweight and 18 average weight girls aged 11-12 years	Interviews that involved completed the child version of the Eating Disorders Examination, the Harter Self-Perception Profile and the Short Moods and Feelings Questionnaire	Overweight girls show some of the psychological features associated with the development of eating disorders, including a link between concerns and self-esteem based on physical appearance.
17. Hill and Waterson 2002	Cross-sectional	Fat teasing in pre-adolescent children	School based study with 283 children (183 girls and 200 boys) aged 9.8 years	Harter's Self perception profile for children and measures of peer popularity and dieting	The relative risk of fat teasing in overweight/obese children vs. normal weight was 3.9%. Fat teased children scored significantly lower on all measures of self-competence and self worth even when controlling for BMI
18. Sweeting and West 2001	Quantitative – first sweep of longitudinal study (see Sweeting et al 2005 above)	Correlates of the experience of teasing and bullying at age 11	Community .Primary age population mean 11 years and 3 months 2,586 participants (1,339 males)	Class based questionnaire completion on health, self esteem and self image, health related behaviour and attitudes, family life, school, leisure activities, friends and projections for the future. Interviews and BMI measures by nurses Class teachers' questionnaires on child's behaviour and ability. Parental questionnaires delivered by children	Experience of teasing/bullying more likely among children who were less physically attractive, overweight, had a disability and performed poorly at school. Finding regardless of sex and class but additive in their effects.

**Table2. 1 continued: Published UK studies on the psychosocial correlates of childhood obesity 1995 – 2009**

<b>Study</b>	<b>Type</b>	<b>Focus</b>	<b>Community / clinical/treatment sample</b>	<b>Methods and research instruments</b>	<b>Findings</b>
19. Dixey et al 2001	Cross-sectional	Boys and girls perception of fatness, thinness, social pressures and health	Community 300 9-11 yr old UK children boys and girls	Focus groups	Natural and self inflicted fat children distinguished. More sympathy for natural fat. Children felt fat children would be bullied. Did not believe thin is good fat is bad.
20 Fox and Edmunds 2000	Cross sectional	Children 's perspectives on their overweight/obese status	Clinical 30 overweight 9 and 10 years old	Individual interviews	Fat children are aware of their condition. Weight related name-calling or teasing from other children is very potent. an awareness of being fat did not seem to negatively affect self-esteem or perceptions of social acceptance.
21 Hill and Phillips 1998	Cross sectional	Body weight influences on self esteem and peer acceptance	Community adolescent female multiple school population 313 participants from Y5	BM1 measurements Body shape preferences (Self-Perception Profile (Harter 1985) Dutch Eating Behaviour Questionnaire (Van Strien et al 1985) Peer nomination questionnaire	Prior to adolescence, physical appearance and athletic competence rather than global self-esteem is affected by overweight. Heavier girls were significantly less likely to be peer nominated as pretty but did not differ in their popularity.
22 Pierce and Wardle 1997	Cross-sectional	Cause and Effect Beliefs and Self-esteem of Overweight Children	9-11 year old clinically overweight children Community comparison group	Weight and height measures. Self esteem questionnaire and follow up interview	Self-esteem differences are related to children beliefs of the cause and the effects of their overweight.
23 Hill and Silver 1995	Cross-sectional	Fat, friendless and unhealthy: 9-year old children's perception of body shape stereotypes	Community 118 9 year old boys and girls.	Ratings of four silhouette figures ratings .Measures of own body shape preference, dietary restraint, height and weight	The overweight body shape was associated with poor social functioning, impaired academic success, and low perceived health, healthy eating and fitness. Gender and the raters own body weight had only limited impact on these stereotypical judgements.

The literature on childhood obesity, including, where relevant, the articles listed in Table 2.1 above, has been summarised into the following domains in order to reflect the major themes that emerged from the search and review of the literature:

- Prevalence and Origins
- Psychosocial Outcomes
- Weight Bias and Stigma
- Management and Prevention
- The Role of Schools
- Implications for Educational Psychology Practice

The conclusion of the chapter attempts to show how key findings and gaps are linked to the research questions of the study.

### **2.3 Prevalence and origins of childhood obesity**

Obesity is reported as a global epidemic affecting all age groups (WHO, 2000). For some commentators, it is not only the scale of childhood obesity that generates concern, but also the speed at which the prevalence has increased, particularly in industrialised countries (Wang and Lobstein, 2006; Deckelbaum and Williams, 2001). Then there are those commentators who argue that the research evidence does not support the notion of 'obesity epidemic' (Evans et al, 2005). For different reasons the pro and anti-

epidemic camps highlight the same factors as key barriers to a clearer understanding of the phenomenon in children. These are the lack of comparable representative data from different countries, and varying criteria for defining overweight/obesity (Gard and Wright, 2005; Jebb et al., 2003).

Currently in the UK, there appear to be two principal ways of defining childhood obesity. The first is the national Body Mass Index (BMI) standard based on UK reference curves from 1990. Children are classified overweight or obese if they fall above the 90<sup>th</sup> and 95th percentile respectively relative to the curve for their age. The other method is the International classification system based on data relating to height/weight (BMI) distributions in 6 countries, including the UK (Rudolf, et al. 2005; Social Issue Research Centre, 2005). In the UK, the two main sources of prevalence data on childhood obesity are the Health Survey for England (HSE) and the National Child Measurement Programme (NCMP). Both used the UK reference curves to elicit BMI data. The HSE 2006 survey involved the interview of 7,257 children that involved core and boost sample groups. It appears that not all the child participants were subject to height (86%) and weight (84%) measurements. However the data indicated that overall, between 1995 and 2006, the prevalence of obesity among both boys and girls increased. Among boys aged 2 to 15, the proportion who were obese increased overall from 10.9% in 1995 to 17.3% in 2006. Among girls, the proportional increase went from 12.0% in 1995 to 14.7% over the same period, although there was some fluctuation between years. The 2006 survey estimate for girls aged 2 to 15 represents a significant decrease from the 2005 figure of 18.3%. Future years'

data will show whether this is part of a downward trend (The Information Centre, 2008). The 2007/8 NCMP entailed the use of data from 477,652 reception aged children and 495,421 Year 6 children. The results showed that in reception year 13.0 % children were overweight and 9.6 per cent were obese and that in Year 6 14.3 % of children were overweight and 18.3 per cent were obese (Hansard, 2009a).

The appropriateness of use of the BMI in the assessment of children has been debated due to its insensitivity to maturation factors (Reilly et al., 2002). It is considered an easy, useful, and least intrusive, but not perfect measure (Edmunds, et al., 2001). Flegal and colleagues (2006) point out that there is a difference between measurement of weight for public health surveillance screening and monitoring purposes versus measurement by health professionals for the purpose of health risk assessment and diagnosis. There is a need to understand the uses and limitations of such methods. Children with a BMI over the agreed cut-off points do not necessarily have clinical complications or health risks related to fatness. More in-depth assessment is needed before taking on a treatment or management course in respect to individual children (Flegal, et al., 2006).

UK research (Saxena, et al., 2004) reflects the trend in developed nations, that obesity is more prevalent in certain populations. Saxena and colleagues (2004) carried out a secondary analysis of data on 5,689 children and young adults aged 2–20 years from the 1999 Health Survey for England. They found that the percentage of children and young adults who are obese and

overweight differs by ethnic group and sex, but not by social class. British African-Caribbean and Pakistani girls were seen to have an increased risk of being obese and Indian and Pakistani boys as having an increased risk of being overweight compared to the general population.

Increased rates have also been identified in:

- low income families. Obese/overweight children are associated with the SES of parents, especially the mother. (Robertson et al., 2007);
- children of parents where there is family/parental obesity (Koeppen-Schomerus et al., 2001). A recent UK study indicated that childhood obesity was mainly confined to those whose same-sex parents were obese, and the link did not appear to be genetic (Perez-Pastor et al, 2009); and
- developmental disabilities. Children with developmental disabilities often have one or more predisposing factors for obesity. These include the coexistence of certain genetic syndromes known to be associated with obesity, reduced levels of physical activity, and the use of centrally acting medications such as anti-epileptics or anti-psychotics that can cause weight gain (De, et al., 2008).

It has been argued that the rapid rise in the prevalence of obesity in the UK and other industrialised nations has occurred mainly due to environmental and behavioural changes relating to diet and inactivity (Scottish Intercollegiate Guidelines Network (SIGN), 2003). SIGN (2003) states however, that no



published UK study has appropriately examined the causal roles of these specific environmental factors. The report from the national government's Foresight Programme summarised that the causes of obesity were extremely complex, encompassing biology and behaviour, but set within a cultural, environmental and social framework (Foresight, 2007).

There is no unifying psychological theory of obesity and often the complex multi-level recursive interactions between cause and effect are unclear (Butor, 2004). Gray and Leyland (2008) argue that the relationship is likely to be bi-directional. Chang and Christakis (2002) state that with regard to consideration of psychological factors, theorists have moved away from psychological *causes* of obesity to contemporary models, which emphasise the psychological *consequences* of obesity. These are explored in depth in the following sections.

## **2.4 Psychosocial outcomes for overweight and obese children and young people – Mapping the evidence to the 'Every Child Matters' framework**

With the reported trends for childhood obesity in the past two decades, empirical efforts have been made to understand the impact of obesity on the child's psychosocial development and functioning (Zeller et al., 2008). This reflects the growing interest, attention and concern with non-physical outcomes of childhood obesity. It also appears to be the preferred focus of

interest for the population under scrutiny. Booth and colleagues' study (2008) with Australian adolescents for example indicated that young people were more concerned about the psychosocial than the physical consequences of being overweight or obese.

Within the literature many different approaches have been used to summarise these outcomes. Some systematic reviews have primarily focused on psychopathological outcomes (Cornette, 2008; Wardle and Cooke, 2005). Others have explored impact in different social contexts (Puhl and Latner, 2007). Some researchers have attempted to use quality of life methodologies that enable a wider exploration of areas in everyday life (Swallen et al., 2005; Warschburger, 2005). The evidence suggests obesity leads to a 'risk profile' with respect to psychosocial development. Nevertheless, without longitudinal data no firm conclusions can be drawn about the nature of the relationship between psychosocial problems and obesity.

In the UK, the challenges and imperatives of the Every Child Matters (ECM) agenda have focused attention on five desirable outcomes for all children (DfES, 2004) (see Table 2.2 below). As these are key drivers in national and local policy and practices within Children Services across the UK, I considered it appropriate to attempt to map the evidence base about psychosocial correlates of childhood obesity to the ECM outcomes.

**Table 2.2: Every Child Matters: the 5 outcomes (DfES, 2004)**

✂ **being healthy:** enjoying good physical and mental health and living a healthy lifestyle

✂ **staying safe:** being protected from harm and neglect and growing up able to look after themselves.

✂ **enjoying and achieving:** getting the most out of life and developing broad skills for adulthood.

✂ **making a positive contribution:** to the community and to society and not engaging in anti-social or offending behaving.

✂ **economic well being:** overcoming socio-economic disadvantages to achieve

### **2.4.1 Being healthy**

Although the focus of this study and this section is on psychosocial correlates of childhood obesity it is important to mention the reported physical health concerns. I do not want their omission to be construed as trivialising potential negative health outcomes. As Monaghan (2005) states, even the highly critical contributors to the obesity debate (e.g. Campos, 2004) accept that extremes of weight, at either end of the light–heavy continuum, are associated with increased health risk.

#### 2.4.1.1 Physical health and well-being

Initially the focus on physical health concerns in relation to childhood and adolescent obesity was the long-term consequence of its persistence into adulthood and associated morbidity and mortality risks (Styne, 2001). Obesity has been identified as a major risk factor for the development of common chronic and disabling conditions such as cardiovascular disease, hypertension and diabetes (WHO, 2000). Child-onset obesity may have worse consequences than adult onset obesity (Dietz, 1998). Children are also seen as more vulnerable to a unique set of obesity-related health problems because their bodies are growing and developing (Daniels, 2006). Recent research indicates many short-term significant health risks associated with obesity in childhood, e.g. type 2 diabetes (Aylin et al 2005); sleep problems and disorders (Beebe et al., 2007); hypertension (SIGN, 2003); asthma (Figueroa-Munoz et al., 2003); and orthopaedic complications (Deckelbaum and Williams, 2001). Regarding the concept of 'increased risk'; the implication is that there may be a cohort within the population of overweight and obese children who do not develop these conditions. The research has yet to explain the nature of the mediating variables or processes that cause such differences in outcome to occur.

#### 2.4.1.2 Psychosocial health and well-being

In comparison with the strong reported evidence of obesity as a risk factor compromising physical health, the evidence for poor psychosocial outcomes

is weaker, highly inconsistent and the causal relationship speculative (Swallen et al, 2005; WHO, 2000). It has been argued that obese children have an increased risk of psychosocial problems that can persist into adulthood (Edmunds et al., 2001). Viner and Cole's (2005) analysis of UK national cohort data revealed that childhood obesity when limited to childhood has fewer adverse adult outcomes than obesity that persists into adult life. The research approach could be described as 'opportunistic' due to the researchers being in a position to apply a set of hypotheses and statistical analyses to an existing set of electronic data. Their data suggested that the long-term social and psychological impact of the apparent epidemic of childhood obesity might be less than previously thought, particularly in those in whom obesity resolves after childhood. The authors do not consider whether the research may also indicate differing characteristics between the two populations, i.e. the fat child to the thin adult, and the fat child to the obese adult. There does not seem to be any questioning that as the original measures used on the cohort were not specifically designed to test the relationship between obesity and psychosocial outcomes, there may be limitations to the validity of those measures.

Research has produced mixed results as to whether girls (SIGN 2003) or boys (Wake et al., 2002) are more at risk. Gray and Leyland (2008) who collected survey data on over 1200 Scottish adolescents found being overweight to be associated with psychological distress in girls aged 13–15 years. The statistically significant relationship remained in girls when account was taken of the other factors of lifestyle and environment. The relationship was not,

however statistically significant for boys. Gray and Leyland (2208) highlight that the strength of their study was gaining reliable weight measures that were carried out by interviewers rather than relying on self-reported measures. However exploring associations between *perceived* weight status and psychological distress is a valid research activity in its own right, as negative body image irrespective of *real* weight status may play a larger role in triggering psychosocial problems (Erikson et al., 2000; Pesa et al., 2000).

Low self-esteem is presented as the most common consequence of obesity (Strauss, 2000). This is despite an earlier review by French and colleagues (1995), which concluded that the association between obesity and low self-esteem was modest and that scores in overweight/obese children generally fall within the normal range. Wardle and Cooke's (2005) more recent review is argued to be consistent with the French and colleagues' review. Wardle and Cooke's (2005) conclusions on self esteem and obesity drew on twenty-six studies conducted within the review's time period of 1993-2005. It is a comprehensive and exhaustive review (Puhl and Latner, 2007). Five of the studies were UK based over the period 1997-2002. All the UK studies seem to indicate poorer levels of self esteem for overweight or obese participants than the non overweight or obese peers. However Wardle and Cooke, despite being British researchers, did not comment on specific national contexts. The authors also fail to highlight the difficulties with a comparative analysis. For example there seems to be an unquestioning acceptance of the use of standard weight status measures, for example the British Mass Index (BMI)

with the sample populations, despite the reported known difficulties of using such measures with children and young people (Jebb et al., 2003).

Sweeting and colleagues' (2005) study with Scottish adolescents is a UK study that found a somewhat atypical relationship between self esteem and weight status relative to the other UK studies. The findings on self esteem were part of bigger study that was designed to provide a response to the need for a well-designed cohort study to look at the prevalence and degree of psychological complications of obesity in children in the UK. School-based surveys with self-completion questionnaires were the key tools used to collect data. The study found at age 11, obese adolescents had lower self-esteem with males also having lower mood. However by age 15 the only reported significant difference between young people was with female self-esteem. Becoming obese was preceded by lower self-esteem and higher victimisation and what was noted was that unexpectedly, this group then showed relative improvements in psychological well-being having become obese.

Despite obesity's identification as a potential protective factor within this cohort, this did not lead to debate about the conceptualisation and possible dissonance with dominant discourses which position obesity as a 'problem'. Rather Sweeting and colleagues (2005) argue that the global efforts to boost self-esteem and address other psychological problems in obese adolescents may not be a useful therapeutic approach. They argue that energies should rather be directed in supporting overweight and obese adolescents with their concerns about further weight increases by the design and implementation of

effective nutritional and activity programmes. This research could support a view that irrespective of whether negative psychosocial consequences occur, there must be no distraction from the primary goal of ensuring a leaner and lighter nation of children.

Franklin and colleagues (2006) have attributed the inconsistency in the studies' outcomes on self-esteem to weaknesses in the design of studies looking at low self-esteem and obesity, such as the conceptualisation and measurement of self-esteem, and the use of small clinical samples in contrast to large representative community samples. Their Australian study sought to address this and showed by age of 11, obesity had a clear and measurable impact on self-esteem especially with girls. However this was only in selected areas of perceived competence, such as physical appearance, and not all obese children were affected.

Studies have also been inconclusive in determining the status of race as a mediating factor. Kimm and colleagues (2002) conducted a 10-year US-based longitudinal study with Black and White girls recruited at the ages of 9 and 10 years. Overall the study found that even at age 9, there was significant negative association between weight status or rather 'adiposity' as described by the authors, as the measure for 'weight' was skinfold thickness rather than the BMI. However the negative correlation between adiposity and self-esteem was significantly less pronounced with the Black participants. The authors suggested that this gives support to the hypothesis that there exists, among Black people, a tolerance towards obesity.



The reviewed studies on self-esteem have also highlighted the use of a range of instruments to measure self-esteem. Research into self-concept and self-esteem has shown that self-esteem is multidimensional. Harter (1983) distinguished six aspects of self-esteem, which determine an 'overall' self-concept. Harter's self esteem questionnaires have been used in over a third of studies included in by Wardle and Cooke's review. However it would appear that studies with obese children, which primarily report such global self-concept (or self-esteem) scores, do not make clear to what extent each aspect of the self-concept contributes to the general ('overall') self-concept (Bosch, 2004).

A number of studies have specifically looked at psychiatric disorders (e.g. Erermis et al., 2004; Mustillo et al., 2003). There have been mixed findings with regards to correlation between obesity and depression (Puhl and Latner, 2007; Wardle and Cooke, 2005). Goodman and Whittaker (2002), through a prospective cohort study demonstrated that depressed adolescents are at increased risk for the development and persistence of obesity during adolescence. This indicates the multidirectional influences at play. A Swedish population study found a significant association between adolescent obesity and depression. Effects of experiences of shame, parental separation and parental employment were said to have explained this association (Sjoberg et al., 2005).

Wardle and colleagues (2006), wanted to test the hypothesis that the strength of the obesity–depression association is moderated by gender, ethnicity and

socio-economic status (SES). Using samples from two UK large secondary schools they found that there was barely any association between obesity and depressive symptoms in either sample. There was also no evidence that obese participants who were female, white or from higher SES backgrounds were especially vulnerable to depressive symptoms. Erickson and colleagues (2000) suggested that girls who reported overweight concerns irrespective of weight status were more likely to report depressive symptoms. Meanwhile, a number of studies have highlighted links between suicide ideation and real and perceived weight status, again with directions of influence and the salience of moderating factors still unclear (Dave and Rashad 2009; Swahn et al., 2009; Whetstone, 2007; Eaton et al., 2005) .

Given Western society's emphasis on the "thin ideal," and the cultural stigma associated with being overweight, some degree of body dissatisfaction or concern regarding one's shape and/or weight is relatively common in both normal-weight and overweight youth and adults i.e., "normative discontent" (Littleton, 2008). Wardle and Cooke (2005) argue that body dissatisfaction is not a unique marker of obesity. However some studies demonstrate that overweight girls appear to be at greater risk of endorsing unhealthy or extreme weight control practices than overweight boys, perhaps reflecting the greater shape and weight concerns seen among overweight girls. The studies have also linked obesity to disordered eating, unhealthy weight control behaviours and bulimia, poor body esteem, and distorted body image, again, with directions of causal influence unclear (Goldschmidt et al., 2008; Crow et

al., 2006; Duncan et al., 2004; Tranosfsky-Kraff et al., 2004; Epstein et al., 1998).

Such correlations are however a concern, not only because of the negative health consequences associated independently with both overweight and disordered eating, but also because each condition may perpetuate the other. That is, if a child is overweight/obese, it increases the risk for disordered eating and simultaneously, disordered eating predicts further weight gain. Moreover, childhood experiences of being overweight/obese and disordered eating are risk factors for full-syndrome eating disorders. Haines and Neumark-Sztainer (2006) have argued for the existence of shared risk factors that may have relevance for the development of a spectrum of weight-related disorders. Disorders can occur simultaneously with each other and may cross over from one to another. The disorders are not a phenomenon found solely in girls; Berg and colleagues (2005) also identified correlates with adolescent male samples.

Fabiractore and Wadden (2004) argue, in their review of adult studies, that the focus of enquiry has shifted from whether obesity is related to greater psychological distress, to the question of which obese people are at increased risk of distress. There is an acknowledgement by these 'second generation' research studies of the heterogeneity of obese persons. The review of studies revealed that for adults, obese females, binge eaters and extremely obese persons are at increased risk of emotional disturbance. For children and adolescents, no reviews have highlighted equivalent risk factors.

Due to the dominance of cross-sectional approaches, studies are probably also unable to give a clear indication or explanation as to whether psychosocial problems develop as a consequence of obesity or are factors that increase a child's vulnerability to becoming obese. Tershakovec (2004) argues that, given the fact that overweight and obese children are frequently the target of discrimination and stigmatisation, it seems likely that psychosocial problems play a role in the exacerbation of obesity even if not involved in the initial aetiology of the excess weight gain.

To summarise the evidence on poor psychosocial outcomes, a conclusion can be drawn that these are not a universal phenomenon for obese children and adolescents (Hill, 2005; Zeller et al., 2004). In spite of the mixed findings on psychological functioning and the warning of 'emotional stigmatisation' (Wardle et al., 2006), the potential of this risk factor cannot be dismissed out of hand, especially in light of the view that emotional health and well being permeate all aspects of children and young people's daily life in schools and contributes significantly to all the ECM outcomes (McLaughlin, 2008; DCFS 2009a). For these reasons the remaining outcomes that are explored below should reflect an interactive context, as the next section on staying safe should demonstrate.

## **2.4.2 Staying safe**

### **2.4.2.1 Risk behaviours**

Farhat and colleagues' (2010) US study with adolescents found significant associations of overweight and obese young people at risk of developing health compromising behaviours such as substance abuse and violence. Strauss (2000) found that obese children with decreasing levels of self-esteem were more likely to engage in high-risk behaviours, such as smoking or consuming alcohol. Conversely Wardle and colleagues' (2006) findings from their study on obesity and depression within the adolescent population indicated that obesity might be protective for behaviour disorder with similar trends regarding substance abuse/dependence. Ironically one explanation given for these 'protective' influences appears to suggest that it is the social exclusion of obese adolescents from peer groups who are engaging in behaviours linked to status and appearance e.g. smoking which can reduce risks of harm. The researchers do not give an account as to how and why this occurs, but one could speculate they are suggesting that these lifestyle factors reduce social interaction opportunities that may have lead to high-risk behaviours.

### **2.4.2.2 Peer victimisation**

Appearance related teasing is the most common form of teasing among children (Hayden-Wade et al., 2005). Weight related teasing can lead to

deleterious outcomes such as potentiating the risk of overweight children and young people developing disordered eating behaviours. Libbey and colleagues' (2008) survey with US female and male adolescents found that the frequency of teasing was related to higher levels of behaviours such as bingeing and eating in secret.

An ever-growing body of literature indicates that chronic peer victimisation is common among overweight/obese children and may contribute to impairing psychosocial functioning (Storch et al., 2007). Evidence of the prevalence of weight related teasing is limited. A US study found that frequent weight-teasing was reported by 45% of overweight adolescent girls and 50% of overweight adolescent boys, compared to 19% of average weight girls and 13% of average weight boys (Neumark-Sztainer et al., 2002). Studies on teasing and bullying have identified that obesity was one factor that made peer bullying more likely (Eisenberg et al., 2003; Pearce et al., 2002; Sweeting and West, 2001; Hill and Murphy, 2000).

Murtagh and colleagues' (2006) survey research indicated that participants considered bullying to be 'normal' behaviour, even to those at the receiving end. This suggests that displays of cruelty to the obese child have become part of normative beliefs and practices in the school environment. Boys reported how bullying had led to retaliation and uncharacteristic behaviour at school, which was then often punished with their own exclusion from school activities. It was often the social rejection and humiliation confronting them in

the school playground and not the threat of future morbidity that was fuelling these boys' desire to lose weight.

A Canadian study (Janssen et al., 2004) with 11-16 year olds indicated that overweight or obese boys and girls were also likely to be perpetrators, as well as victims of bullying, compared to their average weight peers. A UK study (Griffiths et al., 2006) looked at bullying behaviour in 7,000 8 year olds and demonstrated that obese boys were more likely by a factor of 1.66 than their normal weight peers, to be overt bullies and were 1.54 times more likely to be overt victims. While obese girls were 1.53 times more likely to be overt victims. A key limitation of the study was a surprising failure to account for multiple disadvantages. Only SES was controlled for with regard to its established association with obesity. It was surprising that race and disability were not controlled for considering their known associations with bullying (Sweeting and West, 2001; Wolke et al., 2001). Also there was no exploration of what factors protected those who were overweight and obese who did not report bullying behaviours. It would have been useful to explore the experiences of those exceptions to inform interventions for those who were identified as being more at risk.

In line with reported reduce risks for depression, and high-risk behaviours as highlighted above, the UK study by Sweeting and colleagues (2005) also reported reduced victimisation for those who become obese. They offer more speculation than evidence on the cause for this effect. On the one hand they suggest effective anti-bullying policies by schools; on the other hand they

argue that the overweight/obese child's increasingly passive and sedentary lifestyle leads to exposure to fewer of the social interactions which may trigger bullying.

Braet and van Strien's (1997) US study argued that obese teenagers might be more victimised, not because they are obese, but because they have poor social skills. However these claims can be seen as speculative, due to the questionable validity and reliability of the measure used in their study, where the researchers conducted a questionnaire survey on eating behaviour with parents of obese and non-obese children. Whereas the questionnaire may be an appropriate instrument for assessing eating styles it was not designed as a robust instrument to measure, to assess the prevalence of bullying and/or the children's social skills.

#### 2.4.2.3 Safeguarding

The question of child protection within statutory interventions needs to be examined here. This safeguarding theme appears to have been subject to more media than peer review journal commentary. McKenzie (2003) highlights how obesity can become a safeguarding concern, arguing that the over-feeding of children by adults can be regarded as producing significant harm, and so could trigger statutory intervention. The legal situation for obese children remains unclear, and the Nuffield Council on Bioethics' recent public health report called on the government to develop criteria for deciding



when intrusive interventions would be appropriate (Nuffield Council on Bioethics, 2007).

Overall the research appears to suggest that children and young people who are overweight or obese may encounter unsafe situations and bullying in particular, as a consequence of their weight status. Not only is this a cause for concern with regard to the safety of children and young people, but also with regard to possible negative effects on their emotional well being and academic achievement (DfEE, 2000a).

### **2.4.3 Enjoying and achieving**

There is a growing literature linking obesity with poor educational attainment (Oliver et al 2009). Some adult studies have indicated that levels of education appear to be inversely correlated with body weight (e.g. Karnhead et al., 2007). The research findings have also been mixed in the case of child studies. There has been concern about the lack of robust empirical research investigating the correlates and/or effect of obesity on children's educational attainment (Kaestner and Grossman, 2009).

Partial support for a positive correlation between obesity and academic achievement was provided by Taras and Potts-Datema (2005) as a result of their review on nine published studies. All the studies identified at least one

negative association between obesity and school performance with attendance identified as a key variable. Overall, however the authors concluded that the data suggesting an association between the overweight or obese child and levels of attendance was too sparse to allow reliable conclusions. Studies by Geier and colleagues (2007) and Schwimmer and colleagues (2003) reported obese children have a greater risk for school absenteeism. It was not clear whether the missed days were due to medical needs including appointments, or a result of adverse experiences linked to weight status e.g. stigma, and/or bullying and contingent distress and avoidant behaviours.

Datar and colleagues (2004) suggested that obesity in primary-aged children is a correlate marker rather than a cause of low academic performance, with no other direct or indirect association between weight and achievement. A subsequent study involving one of the original researchers found that an increase in overweight status during the first four years of school is a significant factor for adverse school outcomes (as measured by test scores, teacher ratings of social behaviour and approaches to learning) for girls but not boys (Datar and Sturm 2006).

Two recent US national longitudinal surveys have continued the trend of mixed results on the relationship of obesity and educational attainment and also highlight some difficulties in study design. Gable and colleagues' (2008) data from 8,000 children followed from ages 4 to 9 found that overweight children progressed less than their non overweight peers in reading and math achievement, with the overweight appearing to have greater academic

difficulties, and rated lower on academic and socio-emotional factors by their teachers and themselves. Conversely, Kaestner and Grossman (2009) US national longitudinal survey of approximately 2200 children between the ages of 5 and 12 between 1986 and 2004 suggested that, in general, children who are overweight or obese have achievement test scores that are about the same as children with average weight.

However, the two studies are not comparable due to the differences in the design and research methods used, for example the measure of educational attainment. Of particular interest was the differing use of the BMI percentile cut offs to categorise which children were overweight and obese. Another point of interest are the results of another study on a subset of the same longitudinal cohort used by Gable and colleagues (2008). Judge and Jahn (2007) found that, controlling for SES, maternal education, and ethnicity differences, the association between being overweight and academic test scores was no longer statistically significant.

Surveys involving young children's and older youths self-report measures have shown interesting results, indicating that overweight youth rated their school performance and educational future lower than their non-overweight peers (Mellin et al., 2002; Davison and Birch 2001; Faulkner et al., 2001).

In comparison to efforts of identifying associations between obesity and educational attainment, there is less commentary on the nature and direction of causation. Kaestner and Grossman (2009) suggest a number of factors.

First, peers and teachers may discriminate against overweight and obese children, which is likely adversely to affect educational achievement. This suggestion does have some face validity. In light of the key role of teacher assessment in children's attainment, the possibility of biased attitudes of teachers should also be considered a factor, which may contribute to poor performance outcome in some cases. Smith and Niemi's (2003) study of female pupils and teacher assessment, found that the more overweight a girl was, the less intellectually capable her teacher rated her. Latner and Schwartz (2005) suggest that the perception of poorer ability or performance serves to reinforce pre-existing biases about obesity, which in turn may adversely affect children's actual potential for achievement in school and occupational settings.

Secondly, obesity may affect health in ways that lower achievement. Obesity is associated with sleeping disorders (e.g. sleep apnoea) and depression, and these conditions may in turn result in poor cognitive functioning and more missed days of school.

Third, obesity may affect how children spend their time and specifically how much time they spend studying. Kaestner and Grossman (2009) argue that social marginalisation and avoidance of physical/recreational activities could lead to greater time spent on educational activities. This hypothesis resonates with the conclusion drawn from an earlier Italian study that showed obese children had a school performance level significantly higher than their non-obese peers. The authors speculated that obese children were more diligent

in order to be better accepted and to counterbalance negative self-image (Zoppi et al., 1995).

Overall it would appear that another important avenue for research is to determine whether children and young people's academic progress may be affected by their weight status or by weight bias in educational settings and the potential mediators and moderators that influence outcomes (Oliver et al., 2009). As indicated below one variable to explore could be the relationship between obesity and the reported association between social capital, peer relationships and academic achievement (e.g. Crosnoe and Muller, 2004; Guay et al., 1999).

#### **2.4.4 Making a positive contribution.**

Kimm and Obarzanek (2002) state that a striking consequence of childhood obesity is a high level of social exclusion. Research has indicated that obese children attribute their weight as a primary reason for having few friends and being excluded from social activities (Pierce and Wardle, 1997). The WHO Interim Report, Obesity: Preventing and Managing the Global Epidemic lists the risk of obese children being socially isolated among the three special considerations in the management of childhood obesity (WHO 1997). The stigma experiences of children and adolescents are seen often to hinder their social development (Bell and Morgan, 2000).

Peer relations are central to healthy social and emotional development (Gifford-Smith and Brownell, 2003). Two decades ago, Parker and Asher (1987) reported that young persons, who are stigmatised for their weight, might fail to achieve normal social developmental competencies. Zeller and colleagues (2008) highlight how positive and negative interactions with peers would impact on children's social skills, relationship development, psychological and social adjustment. Zeller and colleagues (2008) also cite Aboud and Mendelson (1988) to comment on certain "non-social" attributes, specifically physical attractiveness, athleticism, and academic competence that have been shown to be important for success in children's peer relations. Marginalisation can limit the opportunity for individuals to develop and to practise social skills, which in turn are necessary to build up positive and satisfying social support networks. Both are related to subjective well-being (Sarason et al., 1990).

Strauss and Pollack (2003) provided sociometric evidence that suggested overweight adolescents were more socially marginalised than their non overweight peers, and were less likely to be identified as friends, and as having friends less popular than themselves. A US cross sectional survey (Faulkner et al., 2001) found that obese girls and boys, when compared to their average weight counterparts were significantly less likely to 'hang out with friends'. Another US sociometric study with adolescents by Wang and colleagues (2006) found that lower levels of popularity were associated with heavier body shapes for girls and with both thin and heavier body shapes for boys. However a UK study Hill and Phillips (1999) found that heavier girls

were significantly less likely to be peer nominated as pretty, but did not differ in their popularity.

Some adult research suggests that marginalisation as a result of weight bias is not only directed at obese persons but also attaches itself to those perceived to be in a social relationship with an obese individual (Hebl and Mannix, 2003). This notion of the “spread of stigmatisation” needs further examination to determine whether peers and friends of obese children attempt to avoid negative evaluations by distancing themselves from overweight and obese peers. Penny and Haddock (2006) carried out a study on the ‘mere proximity’ effect with children aged five to ten. They found there was a significant effect with girls and with children as young as five. Penny and Haddock’s (2006) methods were similar to research designs looking at ‘anti-fat bias’ in children where participants are shown pictures of children with varying body sizes and asked who they would be friends with. It is difficult to ascertain how Penny and Haddock distinguished a ‘proximity effect’ from their findings as it could easily just be conceptualised as ‘stigma’ or bias.

Whatever the nature of marginalisation, its impact is clear. Further, risks may be compromised as barriers to access secure and sustain social support and capital through positive peer interactions will have implications for future economic well being (Strauss and Pollock, 2003).

#### **2.4.5 Economic well-being**

Despite the economic benefits gained by the food and diet/healthy lifestyle industries, obesity has health and economic costs to society and therefore it could be argued, a negative contribution to society. The cost of being overweight and obesity is estimated as £7.4 billion per year within the UK (DOH 2004a).

In developed countries, obesity tends to be associated with poor labour market outcomes; in particular, lower wages or earnings (Brunello and D'Hombres, 2007; Lundborg et al., 2007), less wealth (Zagorsky, 2005), and a lower probability of employment (Paraponaris et al., 2005). Several papers have found evidence of a negative causal relationship (e.g. Cawley, 2004; Cawley et al., 2005).

However, a recent British study with adults demonstrated that BMI has a positive and significant effect on occupational attainment in males, but a negative and significant effect in females (Morris, 2007). Other international studies, including another British study have indicated that obesity was a consequence as well as a cause with regards to low income (Gortmaker et al., 1993; Sargent and Blanchflower, 1994). British studies are available to show that socio-economic status is related to the risk of obesity in children. Obesity is more common in middle and low socio-economic groups. Analysis of the social mobility of the population (the rise or fall of SES) confirms the importance of obesity in determining SES. Prevalence of obesity is nearly



twice as high among women who fall in SES, as is the case among those who rise in social class. The simplest explanation for these findings is that the relation of SES and obesity is bi-directional. SES determines the prevalence of obesity, while obesity contributes to the decline in SES. This association between SES and obesity is, however less consistent among young children, males and non-white ethnic groups (Stamatakis et al., 2005; Armstrong et al., 2003).

Job discrimination and the denial of promotional opportunities and the charging of higher differential rates by life insurance industries are further economic consequences experienced by obese individuals (Allon, 1982).

#### **2.4.6 Summary of ECM overview**

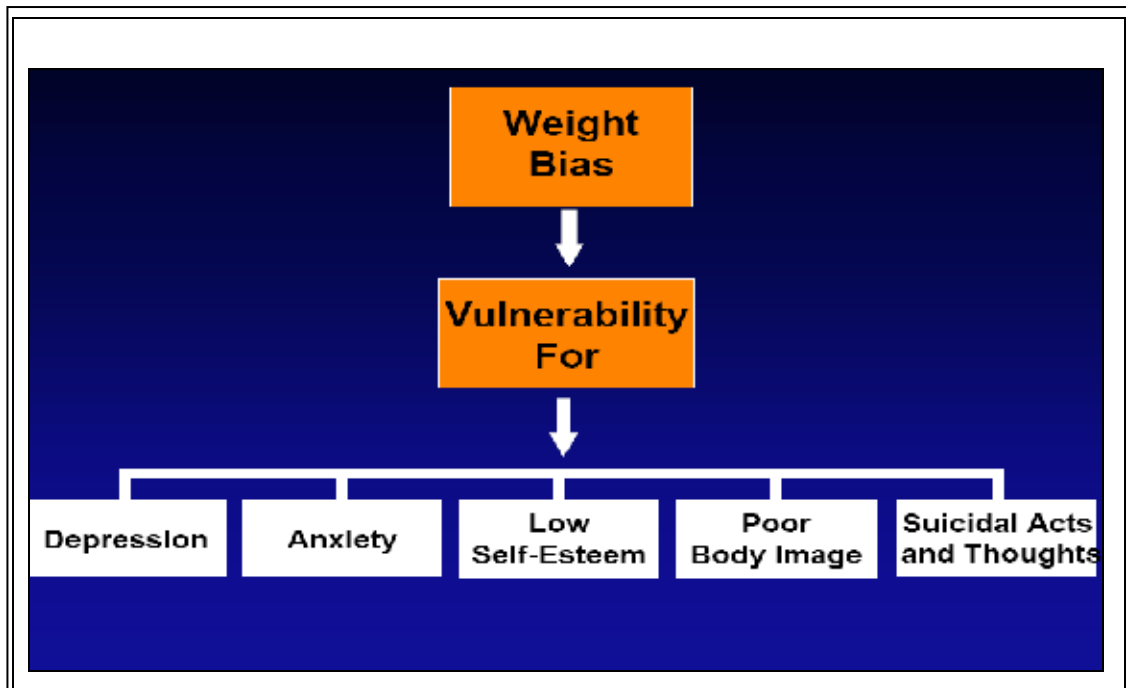
The research does not provide a conclusive or even broad consensus of potential psychosocial outcomes for overweight and obese children and young people. Methodological limitations such as sample inclusion criteria, , definitions and diagnostic criteria, may account for some of the variance between studies: for example, significant differences are likely to be found within obese and 'average' weight from medical clinic samples than between population/community obese samples and average weight samples (Puhl and Latner, 2007; Franklin et al., 2006 ).

Although the use of different methodological approaches and definitions may account for the variability, the research may also be highlighting, albeit crudely, that the population of overweight and obese children and adolescents should not be treated as an homogeneous group. As some commentators have argued, professionals should not go looking for psychological distress in every obese child (Wardle et al 2006; Bosch, 2004). As Wardle and Cooke (2005) speculate, one reason for the 'myth' of poor psychological adjustment in obese children persisting is because of negative stereotyping; clinicians see psychological problems because they expect to.

Even if problems are found, researchers as well as clinicians should question whether their causes lie in the child's weight status or is determined by something else (Hill, 2005). Outcomes will be influenced by a variety of interrelated risk and protective factors that should include a consideration of origins and causes of overweight status within an ecological and socio-cultural framework. A recurring theme in the preceding review of studies that relate to the ECM outcomes is their relationship to the phenomenon of weight-based stigmatisation. Research has indicated that the process of stigmatisation could explain an association between obesity and psychosocial difficulties (Puhl and Latner 2007).

Puhl and Brownell (2007) offer a model, copied in Figure 2.1 below of how stigma/bias mediates psychological outcomes. Puhl and Brownell are associated with the Rudd Centre linked to the Department of Psychology at Yale University. The Centre appears to be the leading research base in the

field of weight stigma/bias. A high percentage of the articles discussed in the following section are a result of the review and research work of Puhl and Brownell and their colleagues.



**Figure 2.1: Puhl and Brownell's (2007) model of weight stigma and**

## **2.5 Weight Bias and Stigma**

### **2.5.1 Nature and Prevalence**

Although the aetiology of obesity may be described neutrally, as a social practice it is neither neutral nor value free (Evans et al., 2002). Although Western societies have placed greater emphasis on the acceptance of human

diversity, hostility towards fatness has been compared with other common social prejudices. Given the high prevalence of obesity in our society, one could hypothesise that the degree of disapproval of obesity would have declined during the last decades. Crandall (1994) drew the conclusion that anti-fat attitudes were at the stage racism was some 50 years ago, namely that anti-fat attitudes are overtly expressible, widely held and more socially acceptable to express than racism.

Weight stigma/bias can take multiple forms: it can include verbal comments, physical bullying, and relational victimisation. Cossrow and colleagues (2001) argued that many types of stigmatisation are subtler than 'prejudice' and 'discrimination'. For example, being stared at in a grocery store did not necessarily fit as an example of weight-based prejudice or discrimination; however, it was an example of being "treated differently or poorly" because of weight.

Current prejudicial beliefs in the Western world are that fat individuals are weak-willed, ugly, awkward, gluttons, lazy, bad, stupid, worthless and/or lacking in self-control (Schwartz et al., 2003). The visibility and perceived controllability of the stigmatised condition have been identified as important determinants of who will be stigmatised and how targets cope with their compromised status (Crandall 2000; Crocker et al., 1998).

Research suggests that overweight and obese youths are victims of bias and stereotyping by peers (Kraig and Keel, 2001), educators (Pryor and Reber

2008; Bauer et al., 2004; Piran, 2004,), and even parents (Davison and Birch, 2001). Latner and Stunkard (2003) report that stigmatisation of fat children has increased by 41% in the last 40 years, the same period during which the prevalence of obesity has increased so dramatically. Content analyses of children's media outputs have also found that the prevailing tendency is to present positive messages about being thin and negative messages about being overweight (Puhl and Heuer, 2009). These co- relational relationships do not support the idea that stigma helps in the prevention and management of obesity.

The derogatory view of obesity is not new. Some of the earliest research published in the 1960s examined children's attitudes. There have been a series of studies (Steffieri, 1968; DeJong and Kleck, 1986; Hill and Silver, 1995; Latner and Stundkard, 2003; Musher-Eizenman et al., 2004, Latner et al., 2007) that have replicated an original study by Richardson and colleagues (1961), all of which have demonstrated that stigmatisation begins at an early age. When children were presented with pictures of children with a range of physical characteristics including disabilities, the picture representing the obese child was one of the least liked and least likely to be considered as a potential playmate by children in the study.

In general, determining specific prevalence rates of bias is difficult because different types of stigmatising encounters and biased attitudes have been examined in the literature, with a variety of assessment methods (Puhl and Latner, 2007). There is a need to examine potential differences in perceived

weight bias/stigma across such variables as gender (Anesbury and Tiggemaan, 2000), age (Latner and Schwartz, 2005), race/ethnicity (Greenleaf et al., 2006) and body weight (Griffiths et al., 2006). Ethnic differences and cultural factors need to be taken into account (Douchis et al., 2001). The results of Van de Berg's (2008) study on race factors in stigmatisation of young people suggested that that weight-based teasing is a problem for all youth, and especially so for overweight and obese youth, regardless of racial/ethnic group. This does challenge the previously cited study that suggested cultural differences in levels of tolerance (e.g. Kimm and Oberzanak, 2002). There is also the issue that most studies appear reliant on self reports to suggest levels of prevalence. It could be argued that these measures can only indicate perceived/felt levels of stigma rather than actual/enacted stigmatising behaviour (Scambler, 1989).

Research also has to account for the social, cultural and political forces that create stigma. The stereotypes of fatness and thinness are commonly held as logical opposites and value-laden in that 'thin is good' and 'fat is bad' (Evans et al., 2004). Excess weight is a common reason for feeling different or undesirable, particularly in a culture where young people are socialised from an early age to believe in the importance of appearance (Musher Eizenman et al., 2004).

Anti-fat bias is also held by overweight and obese individuals themselves. Researchers argue that unlike other minority groups, overweight and obese individuals do not appear to hold more favourable attitudes toward in-group

members and this in-group devaluation impacts on psychosocial and medical outcomes (Wang et al., 2006; Schwartz et al., 2003).

Findings suggest that overweight girls may be particularly sensitive to weight-based stereotypes and may experience poor psychosocial well-being when they internalise stereotypes (Davison et al., 2008). Warschburger (2005) argues that prejudicial attitudes alone are not sufficient evidence that a personal attribute such as obesity is stigmatising. Rather, the stigma process may also encompass both the *actions* of individuals and agents of social institutions who denigrate and exclude, as well as the *reactions* of persons in the devalued social category. Hence an interactionist framework is involved.

### **2.5.2 Theories**

Puhl and Brownwell (2003a) argue that attribution theory is a key theoretical approach, due to the relative empirical support available to explain the reasons for stigma. Musher-Eizenman with her colleagues (2004) assessed pre-school children's control attributions for weight and the relationship of these attributions to attitudes and behavioural intentions toward children of different body sizes. Internal attributions of weight control were related to less positive adjectival ratings for overweight and obese children. However the authors report that the children's friendship selections were not contingently affected.

Dixey and colleagues (2001) conducted a study involving focus group discussions with 300 9-11 year old UK children. Questions were asked about whether it matters if someone is fat or thin, whether the fat child should take any action, what problems might they have and the relationship between fatness, thinness and health. Considerable complexity emerged; children divided fat children into those for whom it was natural and those for whom it was self-inflicted. They showed a great deal of sympathy for “naturally” fat children, and far less who had ‘allowed’ themselves” to become fat.

DeJong’s (1980) study with adolescent girls demonstrated that unless an excuse could be offered to explain weight status, or successful weight loss occurred, an obese girl was given less positive evaluation and was less liked than a normal-weight peer. These results suggested that the relationship between body size stigmatisation and control attributions are consistent with attribution theory for children.

Research on bias reduction has demonstrated mixed findings. Several studies have attempted to change attributions of controllability of body weight through education about biological factors influencing obesity. Anesbury and Tiggemann (2000) investigated whether changing children’s beliefs about the controllability of obesity would reduce their negative attitudes toward fat people. Here the experimental group was presented with a brief intervention which focused on educating participants regarding the uncontrollability of weight. The study found that the intervention was successful in reducing the amount of controllability that children assigned to obesity but was not



successful in reducing negative stereotyping of the obese among the experimental group compared to the control group. The results indicate that while children's beliefs about the controllability of obesity can be changed, reducing their negative stereotyping is more difficult.

Klaczynski (2008) suggests that attribution theory cannot provide a satisfactory account for the origins of stigma associated with obesity stereotypes. First, attribution theory cannot account for the early emergence of these stereotypes. Second, with respect to obesity, attribution theorists have not explained observations that the strength of obesity stereotypes increases from preschool to the end of high school. Third, age-related increases in obesity stereotypes are only partially mediated by causal attributions and social identity. Fourth, attribution theorists have yet to propose a compelling mechanism by which stereotypical beliefs affect behavioural reactions to obesity. Specifically, even when negativity toward the obese decreases after manipulations of causal beliefs individuals continue to treat obese persons poorly.

Klaczynski (2008) goes on to suggest that social learning, and social identity theories also have little value in explaining obesity stereotypes and argues that, conversely, it is that these theories are missing some critical element that might better explain why children find obesity to be so aversive. Klaczynski (2008) proposes children have explicit beliefs that obesity is an illness or that children explicitly recognise the similarities between obesity and certain illnesses; children are implicitly aware that an illness-like "wrongness"

characterises obesity and children's reactions to obesity operate according to the laws of contagion. It is this inexplicable sense that motivates avoidance of unfamiliar obese individuals. This conceptual framework could be linked to the Hebl and Mannix's (2003) "spread of stigmatisation" hypothesis mentioned above (p50).

Freidman and colleagues (2005) call for experimental or longitudinal studies to investigate and establish causal connections between stigmatisation and psychological adjustment. Lee and Shapiro (2003) argue that the conclusion that such problems are simply a result of psychosocial or environmental factors related to society's stigmatisation of overweight people is too narrow. Consideration for psychological status before and after weight gains and not limiting studies simply to those people who are already obese can provide greater insight into this poorly understood area. Again Lee and Shapiro (2003) argue for large-scale longitudinal and population-based studies to establish the nature, direction and scale of causal relationships.

### **2.5.3 Coping behaviours and resilience**

Puhl and Brownell (2003b) argue that what contributes more strongly to risks of psychological well being compromised is not the stigmatising situation itself but the ways in which an individual copes with these experiences. Although there is available documentation of bias and discrimination toward overweight persons, less is known about how overweight individuals cope differentially

with weight stigma. Puhl and Brownell (2003b) identified a range of coping mechanisms through a review of adult studies on weight stigma and other relevant areas such as race and gender bias. These are summarised in Table 2.3 overleaf.

Fox and Edmunds' (2000) interviews with 30 extremely overweight 9- to 10-year-old children in the United Kingdom identified that children were beginning to use coping strategies to deal with negative aspects of being fat. Friends were seen as an important element of support. There is a gap in the research to provide evidence whether the nature and use of these coping strategies occurs in children and adolescents who are overweight and obese and can account for the differential outcomes with regards to psychosocial functioning. There also needs to be a consideration that adults, due to factors such as social capital, independence and cognitive maturity, have more autonomy and opportunities to develop and exercise these coping skills than children and adolescents.

Resilience is the phenomenon of positive adaptation despite significant life adversities (Luthar et al., 2000). Factors contributing to resilience in obese and overweight children and young people are unclear (Wardle and Cooke, 2005). In general it is argued that children who show strong resilience have access to protective or mediating factors in three broad areas: within themselves, in their families and within the communities in which they live (Place et al., 2002).

**Table 2.3: Summary of the range of coping methods to deal with stigma identified by Puhl and Brownell (2003)**

**Confirmation and self-acceptance of stereotypes** The stigmatised gradually behaves or thinks in ways consistent with stereotypes

**Self protection strategies** E.g. selectively minimising domains in which one is perceived as inadequate and valuing other domains in which they excel in other attributes

**Compensation** Becoming skilled in activities for which they might not otherwise receive positive attention

**Personal attribution** Obese individuals defended themselves by providing permissible reasons for their weight

**Negotiation of identity** One option is to separate oneself from one's social identity through denial or decreasing the importance. The other is identity enhancement that is to reaffirm or extend existing identity through intensified group contact

**Confrontation** Confronting the perpetrator of stigma can lead to feelings of empowerment and potentially reduce stigmatising behaviours;

**Social activism** Undertaking political action to secure rights

**Avoidance and psychological disengagement** Avoidance of social interaction. Disengagement uncouples self esteem from performance in certain domains

**Communal coping** Cooperating with others to deal with a shared problem

**Losing weight** Removing oneself from the stigmatized group

Allon (1982) reported the absence of any systematic research on healthy, relatively, happy and well adjusted fat individuals who feel good about themselves. This appears to be an ongoing significant omission from the body of available research which can inform evidence-based interventions. The notion that being overweight and obese may be freely chosen, and valued is rarely entertained (Evans et al., 2002).

Although research attention to weight bias has increased, Puhl and Latner (2007) identify many gaps in our knowledge. Further research is needed in order to inform a more comprehensive and finely nuanced understanding of the nature, extent and consequences of weight stigma for overweight and obese individuals of different ages, gender, and ethnic backgrounds. Research is also needed to identify effective methods for reducing bias, and to test interventions that lead to lasting improvements in attitudes and behaviours toward obese individuals and also to explore experiences of overweight and obese children and young people who have high self esteem, good relationships and social health. It would appear that the doing and use of such research is a potential casualty in the national and local responses to the 'war on obesity'.

## **2.6 Management and prevention of childhood obesity**

### **2.6.1 Management**

The Government has set itself the challenging target of reversing the rising tide of obesity and overweight in the population with an initial focus on children (DOH 2004b). A key aspect of this is an agenda of universal prevention and promotion of healthy lifestyles.

Management or rather treatment approaches have to date, principally involved special provision for an identified population. Commentators advocate that for most overweight children, weight maintenance rather than weight loss is an acceptable goal (Rudolf, 2004; Edmunds et al., 2001). Many different kinds of treatment for obesity have been investigated including diet changes, exercise, surgery, medication and psychotherapeutic interventions. The UK is also following the trend of the US in residential obesity 'fat camp' programmes (Gately et al., 2005; Holt 2005).

Parental involvement has been advocated as a key factor for those interventions that have been described as the most effective. Edmunds (2008) highlights from her findings from a study involving parent interviews that the priorities of parents were often the 'softer issues' rather than the rigid focus on physical activity and diet. These issues included 'reactions of others', 'learning to cope with their size', 'clothes' and the 'impact of teasing and bullying'. For the young people themselves it is argued that the current medicalised health

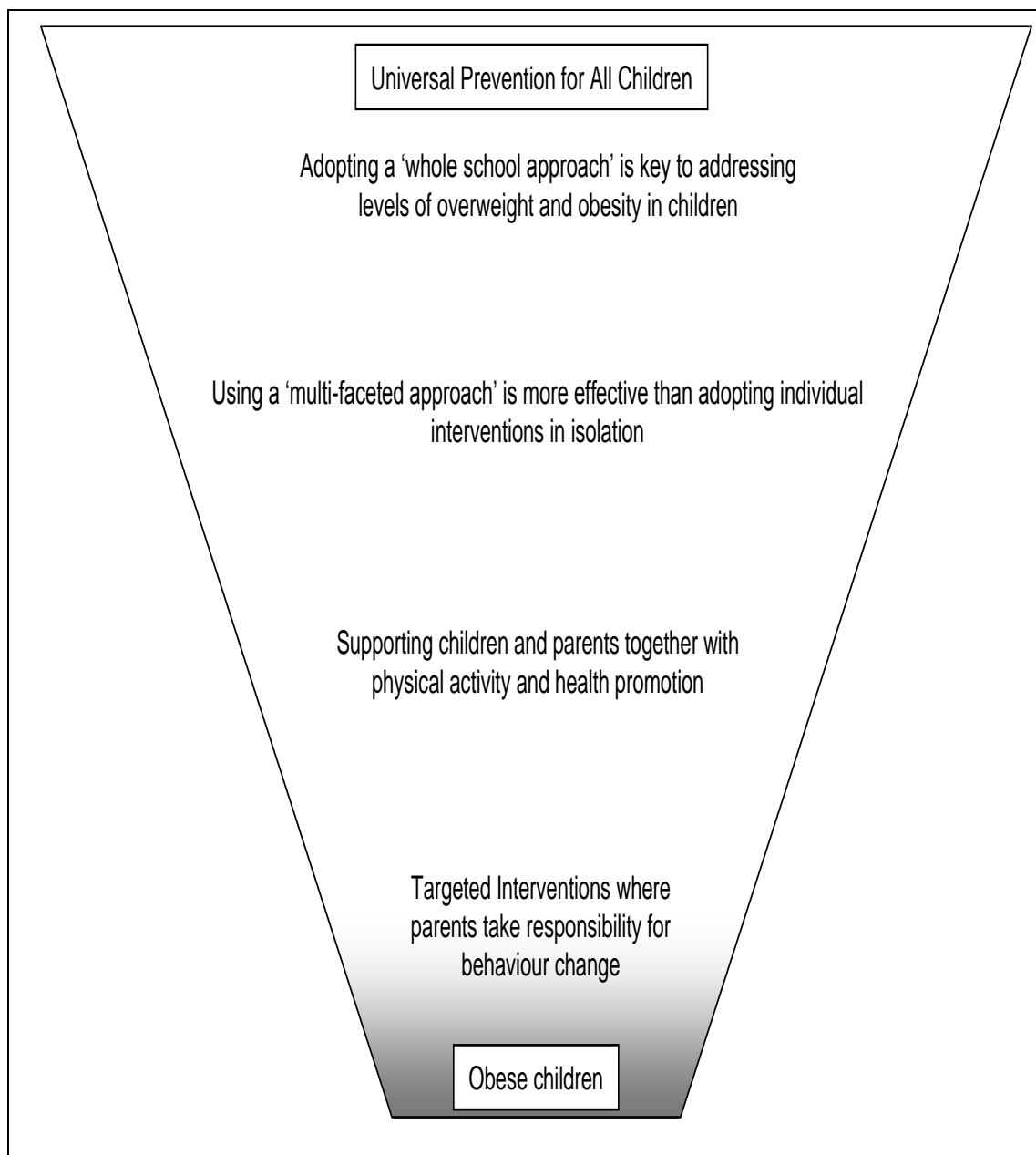
promotion and public health messages about overweight and obesity do not resonate with the majority of young teenagers (Wills et al., 2006). Most interventions emphasise healthy eating. Bullying and a desire to 'fit in' more than health needs appear to be the primary drivers that motivate obese children to lose weight (Murtagh et al., 2006).

### **2.6.2 Prevention**

Prevention requires a targeting strategy to identify those at risk of or a broad sweep strategy that has potential benefits for all (Caplan, 1964). Policy documents such as the recent 'Healthy Weight, Healthy Lives' (Cross Government Obesity Unit, 2008) clearly show a dual strategy approach, giving particular emphasis to the "broad sweep approach" to include non health partners such as children's services and schools. Figure 2.2 is a visual representation of the main principles for prevention approaches from the NICE Guidance and Obesity School Toolkit (2006)

Recent systematic reviews have concluded that few obesity prevention interventions have been shown to be effective in children (Stice et al., 2005; Summerbell et al., 2005). Most studies found no strong evidence that interventions prevented weight gain or obesity, and many studies were limited in design, duration, or analysis (Kipping et al., 2008). The applicability of the findings to children of diverse ethnic and socio-economic backgrounds is also inconclusive (Larkin and Rice, 2005).

**Fig 2.2: Visual representation of the main principles from the recent NICE Guidance and Obesity Toolkit (2006) – summary produced by the National Healthy Schools Programme**



### 2.6.3 Socio-Ecological Models

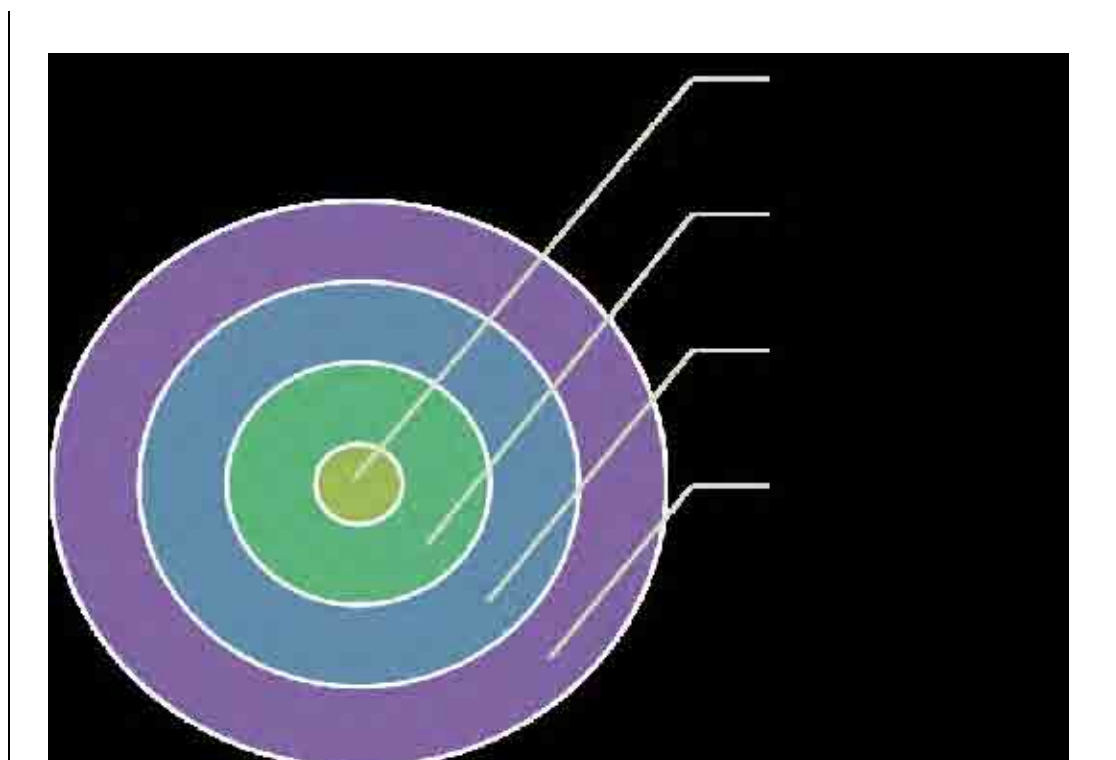
Egger and Swinburn (1997) argue that a shift is needed away from the traditional view of obesity as a personal disorder that requires treatment.



Here, obesity is regarded as a normal response to an abnormal pathogenic “obesogenic” environment. Hills and Peters (1998) propose that we ‘cure’ the obesogenic environment to reverse the obesity epidemic, rather than simply focus efforts on those who have become overweight. Application of socio-ecological models, to inform such ‘cures’ / interventions that target multiple levels of influence, in multiple settings have been developed within health promotion initiatives (e.g. Robinson, 2008; Stokols, 1996).

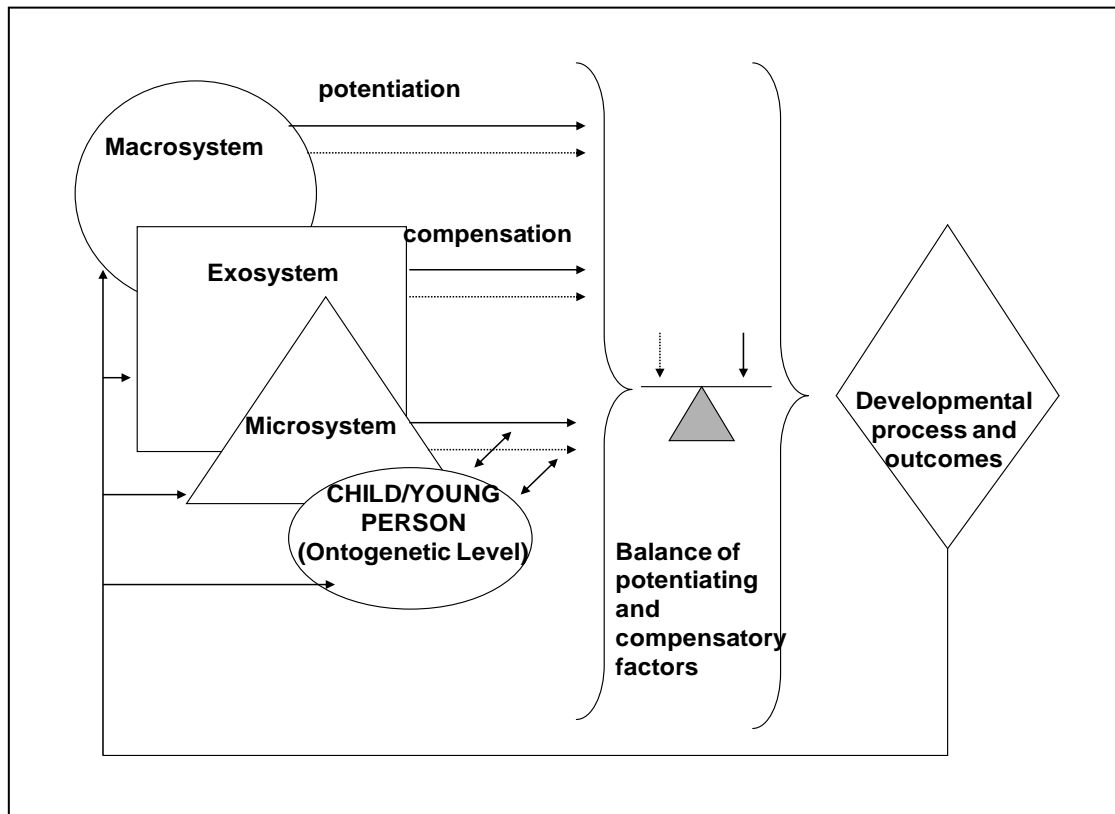
Davison and Birch (2001) recommend the use of Ecological Systems Theory to show the bi-directional rather than uni-directional relationships among the different levels of influence, and consider how factors at one level moderate the influence of factors from another level as demonstrated by Figure 2.3 below.

**Figure 2.3: Ecological Systems Theory’s model of predictors of childhood overweight Adapted from Davison and Birch (2001)**



It can be argued that a limitation of this model is the focus on weight status. In light of the reported research here, this would be a somewhat unreliable indicator and result in too narrow a focus that could potentially wrongly homogenise physical and psychosocial outcomes and minimize the role of weight bias and stigma on those outcomes.

Interventions could be better informed by applying an 'ecological-transactional' (ET) model such as offered by Lynch and Cicchetti (1998) and developed by Cicchetti and colleagues (2000). This ET model, illustrated by Figure 2.4 overleaf, could be considered a more robust and comprehensive, ecological systems model to account for individual differences in physical and psychosocial outcomes. The ET model positions ecological contexts as a number of nested levels with varying degrees of proximity to the individual. The macrosystem involves cultural beliefs and values that permeate societal and family functioning. The ecosystem consists of the neighbourhood and community settings in which families and children live. The microsystem incorporates the family environment that children and adults create and experience (Lynch and Cicchetti 1998). The ET model provides a more descriptive account of the complex interactive, multi-directional, and transactional relationships that shape individual (and context) development and adaptation over time, in particular the nature and balance of the risk potentiating and compensatory factors from each nested contexts. For example, using the model one could consider the impact and tensions of cultural values on beliefs about the thin ideal within obesogenic contexts.



**Figure 2.4; Ecological-Transactional Model of mediating influences upon levels of overweight and obesity in childhood and adolescence and their wider impact on the developmental process and outcomes (adapted from Cicchetti et al 2000)**

#### 2.6.4 Achieving the thin ideal

There appears to be no question that the primary objective within the dominant childhood obesity discourses is the ideal of the medical, social and political norms of what constitutes a 'healthy weight'. Although there is recognition of and expressed intent to address the bias/stigma experienced by children and young people who are overweight and obese, it appears to be considered as complementary to, rather than an alternative to weight management approaches. There appears to be a dominant discourse that the

primary and perhaps best way to help children to cope with bias/stigma and address associated negative psychosocial outcomes is to help them to become thin.

There are mixed findings with regard to whether children and young people achieving the thin ideal leads to improved psychosocial outcomes. Braet and colleagues' (2004) evaluation of a treatment programme with a clinical sample of Dutch children aged 7-17 years did indicate improvements in psychological functioning associated with successful weight loss. However the Department of Health has stated that weight loss does not necessarily resolve the problems of depression and low self-esteem (DOH, 2006). Although research evidence is not given, Puhl and Latner (2007) argue that the experience of teasing and victimisation may have lasting harmful effects that persist even once an overweight child becomes thin. Also discrimination could continue during or after weight loss.

A concern is that if discourses of which idealise the 'norm' or expectations to change to the 'norm' were being used for other socially marginalised groups of children and young people this would be seen as unethical, immoral and illegal (Allon 1982). The increasing medicalisation of obesity (Chang and Christakis, 2002) and its status as a disease appears to have made this permissible. Evans and colleagues (2008) argue that the generation of a moral as well as a political crusade, in which children, identified as a population 'at risk' of developing obesity and associated diseases, and *one could add here psychosocial problems*, has led to an agenda where children

and young people are positioned as being in need of 'saving'. Such discourses have also entered into the educational realm. Schools have been targeted as sites for instruction, regulation and surveillance of children's bodies (Gard and Kirk, 2007).

## **2.7 The Role of Schools**

### **2.7.1 Sites and targets of intervention**

Schools are popular settings for the implementation of interventions, including health promotion as they offer continuous, intensive contact with children (Konu and Rimplea, 2002). It has been recommended that schools have an integral role to play in reducing childhood obesity (Zametkin et al., 2004; Barlow and Dietz, 2002). Primary schools are considered ideal settings for school-based prevention, as the primary school years are considered risk ages for onset (Sharma, 2006).

Although it has been argued that schools are often seen as sites for intervention rather than targets of intervention to address public health concerns (Herman et al., 2004), recent government initiatives are changing that. In the UK, schools have played a crucial role in the National Child Measurement Programme (NCMP) (DCFS/DOH 2007) which seeks to collect local data on the heights and weights of children in Reception and Year 6 to enable Primary Care Trusts (PCTs), Local Authorities (LAs) and schools to

gain a better understanding of the nature of obesity in their locality. Through the 'Extended Services' agenda (DCFS, 2007a), schools are also developing their responses individually or in clusters to the challenges faced by increasing levels of childhood obesity. The aim of Extended Services previously known as Extended Schools/Provision is for services and agencies to work together to provide a range of activities and support to meet the holistic needs of children, young people, families and the community (DCFS, 2007a).

### **2.7.2 The National Healthy Schools Programme**

The National Healthy Schools Programme (NHSP) is currently the main vehicle through which schools and extended services clusters have become key partners in national and local initiatives focusing on prevention of childhood obesity. Informed by pre-existing projects on the role of schools in health promotion (e.g. Moon et al 1999; Rogers et al., 1998), the NHSP was the government's response in England and Wales to the World Health Organization (WHO) Health-Promoting Schools Framework (WHO, 1998; Curtis, 2008). This outlined a holistic approach to foster health within a school and its local community by engaging health and education officers, teachers, students, parents, and community leaders in making common efforts to promote health. A Healthy School considers the health and wellbeing of pupils in everything it does ([www.nhs.uk/Livewell/Healthyschools/...](http://www.nhs.uk/Livewell/Healthyschools/...)). The whole school curriculum teaches the importance of:

- emotional health and wellbeing;

- Personal Social and Health Education (PSHE);
- physical activity; and
- healthy eating.

The guidance from the NHSP does highlight the themes of healthy eating and physical activity being key to contributing to the reduction of obesity levels. However the remaining two themes - emotional health and wellbeing and PSHE - are arguably equally important (Healthy School Website, 2009a).

The NHSP is run jointly by the Department of Health and the Department for Children, Schools and Families (DCSF) (now the Department of Education (DfE)). It was intended to be in all schools by 2009 (Noble and Robson, 2005; Warren et al., 2003). In 2005, Warwick and colleagues reported that schools still had some way to go in implementing the initiative fully (Warwick et al., 2005). By the end of 2008, 97 per cent of schools were participating in the Healthy Schools Programme with 71 per cent having achieved full Healthy School status (Hansard, 2009b).

The National Institute for Health and Clinical Excellence (NICE) published its clinical guidance on obesity in December 2006, which includes guidelines on the contribution that schools can make to tackle obesity. Schools are seen as providing the universal first wave in prevention. Schools are asked to work closely with agencies delivering interventions for more groups if children and young people are identified, presumably by weight status for specialist programmes. NICE states that such programmes need to be evidence-based

and respect children's rights to privacy and protection. The programmes should also not provoke bullying or stigmatisation. It is not clear whether NICE assumes such safeguards are a matter of course with the universal approach schools are asked to provide.

Fox and Edmunds (2000) argue that as is the case with parents, teachers often find issues related to weight difficult to deal with. They speculate that many teachers are themselves overweight and are reluctant openly to discuss this. Another of their hypotheses with more face validity is that teachers may have to face conflicting objectives; on one hand, there is a need to maintain a child's confidence and self-esteem, which lead to their downplaying, ignoring, or even denying the problem. On the other hand, there is a need to break into the behavioural cycle that contributes to the obesity, and the psychosocial distress as well as health risks, this can precipitate. Fox and Edmunds (2000) summarise that what youngsters need is a friendly and non-threatening setting where there is unconditional acceptance of the condition and support to adopt strategies to address the problem at a gradual and sensitively attuned pace.

Currently, there is no conclusive evidence that any benefit has been demonstrated for school-based approaches to obesity prevention. In the US, there has been limited identification of intervention components, which offer more promising outcomes (Kropski et al., 2008). Meanwhile, in the UK, the problems of overweight and obesity are not considered the sole



responsibilities of schools, and the government does not expect schools to provide all the solutions (Cross Government Obesity Unit, 2008).

O' Dea (2005) advocates a 'First do no harm' principle for any planned health promotion intervention in schools. Her concern is focused on the potential of ill-judged or ill-informed well-intentioned health messages leading to inadvertent undesirable outcomes such as the uptake of dieting and slimming among girls, and/ or further stigmatisation. Well-intentioned health promotion messages could also further reinforce normative standards of success which obese children and adolescents are constantly reminded they have not achieved (Evans et al., 2004).

In this context, it is worthy of note that the most common place where children experience weight bias is in school (Latner and Schwartz, 2005). Research has also indicated that teachers hold limited understanding or recognition of bullying in relation to social exclusion (Naylor et al., 2006). Therefore stigmatising behaviours directed at overweight/obese children may be under-identified and inadequately addressed in schools. Leading commentators have argued more research is needed to understand the sources of stigmatisation and approaches to stigma reduction (Puhl and Latner 2007; Brownell, 2005). However attempts to address stigmatising behaviours or help children and young people who are overweight/ obese may lead to another set of unintended negatives outcomes. Gott (2003) argues that identifying any vulnerable individual or groups carries its own risks and may be counterproductive to inclusion. All that would be achieved is one surveillance

approach focused on children and young people's weight status being replaced by another focused on challenging anti-fat biases.

Booth and colleagues (2008) draw attention to the need to elicit the views of young people who are the targets of interventions to reduce the prevalence of obesity. There is a need to understand their concerns and to incorporate their ideas and perceptions into sensitive and effective interventions. Actions that violate or ignore these principles will invite embarrassment, discouragement, and alienation, which are only likely to add to these children's problems rather than help solve them. It can be argued that the same principle should also apply to interventions that aim to address the potential impact of prejudice and stigma.

Curtis (2008) points out that the NHSP was developed as part of a wider government agenda commitment to promoting social inclusion. Using evidence from a research study on the school experiences of secondary aged male and female pupils identified as obese, Curtis (2008) concluded that such programmes may fail adequately to address the experiences of marginalised and vulnerable groups. Curtis (2008) was able to access participants through a community-based intervention programme and carried out focus groups and individual interviews with young people. Findings indicated that the activities prioritised within the programme, such as physical activity and healthy eating, may contribute to the marginalisation of young people and play an important role in the construction of beliefs that their young bodies are inherently undesirable. Curtis (2008) argues that enabling the voices of obese young

people to be heard within a whole school approach may not in fact be possible, due to the fat-normal sizism that typically exists within schools, which is reinforced by the NHSP and serves to silence and devalue these voices.

The review of the literature has demonstrated a complex phenomenon involving psychosocial issues of which the medically-orientated evidence base needs to be interpreted appropriately and perhaps with caution within a social constructive agenda in order for schools to manage the tensions through creative solutions. In England, one could envisage a role for educational psychology services in supporting such developments. However this review has also indicated that currently such a prospect is theoretical rather than realised in practice.

## **2.8 Implications for educational psychology practice**

### **2.8.1 A new priority?**

In England, Educational Psychology Services (EPSs) have had to review their service delivery functions and priorities as a result of the challenges and imperatives of the Every Child Matters (ECM) agenda (Farrell et al., 2006; Baxter and Frederickson, 2005).

Discussions within and between services may include reflections on whether the extended range of 'additional' needs that 'every' child may present, will lead to changes in the identification and prioritisation of the vulnerable groups of children who are considered relevant for EPSs' delivery to families, schools, settings, extended provision, organisations and communities within a multi-agency framework. Within these changing contexts, traditionally targeted groups, such as pupils with SEN, may no longer be either the sole or primary focus of systemic activities, consultation and casework by Educational Psychologists (EPs).

Sutton (2005) argues that obesity is one issue that genuinely touches the working and everyday lives of psychologists – health, social, sport and exercise, clinical, educational, counselling, and neuropsychology. All such psychologists deal with the causes and consequences of obesity. However this review of the available professional literature indicates that the needs of overweight and obese children and adolescents have not been an explicitly targeted focus of work for EPSs and EPs in England. Psychologists working in the US have started to identify this work within their role. Pyle and colleagues (2006) advocate US school psychologists helping in the creation of supportive environments and also using their knowledge of psychosocial correlates and expertise in assessment and intervention to inform school-based responses. The authors' comments appear however to support the discourse of the thin ideal rather than adding challenge to it.

This apparent omission of interest in the obesity agenda within educational psychology practice in England has continued, despite the increasingly alarmist context of the reported pandemic (Kimm and Obarzanek, 2002) and the threat of the impact on the physical health and psychological development, and emotional well being of high numbers of children and adolescents, with the associated economic costs (Reilly et al., 2003). The increasing engagement of schools through national policy-driven measures such as the NHSP in supporting and developing interventions to prevent and manage the childhood obesity 'crisis' also appears not to have raised the proactive interest of educational psychology professionals. This is in comparison to clinical psychology colleagues who have been positioned as able to make a significant contribution towards an effective response (Chadwick and Crocker, 2005).

EPSs and EPs are key agents in promoting inclusive practices (Rosenthal, 2001) and emotional well being/mental health (NHS/HAS 1995, Farrell et al., 2006) for children and young people. It has also been argued that EPs are well placed to ensure children's views are both elicited in a neutral way and included in plans drawn up to address their needs and promote their well being (DfEE 2000b). The changing work contexts for EPSs within children's services mean that they are in a strong position to ensure that multi/inter-agency interventions and evaluations take into account and question the social processes at work in determining desired positive developmental outcomes for children and young people, including those whose weight, body

image, eating and exercise habits give cause for concern and where their social experience and life satisfaction may be jeopardised in consequence.

It is my opinion that EPs need to contribute to the discourse to influence and support the creation of solutions at all socio-cultural ecological levels in order to reduce risks of the marginalisation of overweight and obese children and young people. EPs' knowledge and use of research places them in a position to interpret and challenge when appropriate for stakeholders, the research evidence being provided by the dominant view of science (Evans et al., 2008).

### **2.8.2 Potential new areas of work**

Potential challenges and directions for practice for EPSs and EPs could include:

- through research, giving a voice to overweight and obese children and adolescents, which few studies have included (Hill and Lissau, 2002). Young children identified as vulnerable are not always asked for their views by those making decisions about their lives (Aubrey and Dahl, 2006);
- developing work with families to promote positive familial relationships that will help to attenuate the adverse associations between weight status and poor psychosocial outcomes;

- supporting settings, schools and extended provision through programmes such as the NHSP to reduce the stigmatising culture via their anti-bullying and inclusion policies and practices;
- implementation and application of research to identify the resilience and protective factors that enable good psychosocial outcomes for overweight and obese individuals and inform practice for improving the emotional well being of those identified as a cause of concern in this regard; and
- using the research evidence explicitly to question and inform local policy and multi-agency approaches so that these do not become a one-size fits all approach that ignores individual differences, needs and outcomes of the heterogeneous group of overweight and obese children and adolescents (BeLue et al., 2009).

A starting point for EPs and EPSs is self-reflection about their current positioning on childhood obesity and the nature of potential or actual bias and stigma in their own practices (Davis-Coelho, et al., 2000).

## **2. 9 Conclusion and final research questions**

This review of the evidence on psychosocial correlates of childhood obesity including weight stigma/bias has highlighted certain gaps and weaknesses. First, there continues to be a dearth of UK studies; US studies dominate the literature (SIGN, 2003). Secondly, medical or health professionals and educators including clinical and academic psychologists dominate the research activity in child and adolescent obesity. At present, in the UK, obesity research is seen as fragmented, split mostly across medical and social sciences, leading to calls for more multidisciplinary research (Foresight, 2007).

Thirdly, the lack of consensus and inconsistent findings in some key areas are in sharp contrast to the confident and uncompromising assertions of some commentators, particularly the media, that for overweight and obese children and adolescents negative outcomes are an inevitable and universal outcome: there is a discourse of 'conviction and certainty' (Gard and Wright, 2005).

Fourthly the research approaches used limit the voice of the child in informing discourses on the issue. Methods used generally reflect research 'on' rather than research 'with' children and young people who are overweight and obese (Wills, et al., 2006).

Despite the uncertainties around measurement and prevalence, the notion of a crisis or epidemic, physical and non physical correlates, one conclusion that



can be reached is that obesity is perceived as a serious health problem, especially in the socio-cultural ecological contexts which stigmatise it. Some research also suggests that negative psychological consequences of obesity are more of function of the bias experienced by the individual than the obesity itself (Schwartz and Puhl, 2005). For those obese/overweight children who may be identified at risk of physical and psychosocial difficulties, the evidence suggests that the family and school are the key systems requiring action by services, including education and health professionals, to support management and prevention initiatives. Therefore educational psychology in England is in a position to evaluate its current position and assume responsibility for a more active role within the childhood obesity agenda. EPSs and EPs can offer applied psychological perspectives on childhood obesity to families, schools and communities and this should include carrying out, as well as critical use of research.

As an educational psychologist, my research here was a means to develop a more active role within the childhood obesity agenda and attempt to address some of the gaps and weaknesses identified. The majority of the UK studies have been focused on identifying relationships between childhood obesity and psychosocial outcomes. There only appears to be one UK study that has focused on the possible negative impact of the NHSP on children and young people identified as overweight and obese in schools (Curtis, 2008). The review has shown that a closer look at the NHSP and how schools and their partners are dealing with the challenge of minimising “unintended harm” through initiatives was is appropriate focus for of my research.

I felt the literature review had addressed the first two of the research questions that were cited in the Introduction Chapter (p9) and reiterated here in Table 2.4 below. The last 3 research questions now form the focus of my research study.

**Table 2.4: The original research questions**

- *Can the evidence base on the psychosocial correlates of childhood obesity be mapped onto the ECM outcomes as well as highlight significant gaps in research?*
  - *Does the evidence base on the role of weight bias/stigma provide a valid account of its mediating or moderating role in the causes and/or consequences of obesity?*
1. What are the approaches that are being promoted by partners, particularly schools, within an Extended Provision Cluster regarding the prevention and management of child and adolescent obesity?
  2. Do the shared and differential perspectives on policy and practice indicate how such initiatives serve to address and prevent potential negative psychosocial outcomes?
  3. What are the experiences and views of children and young people on childhood and adolescent obesity and on the role and impact of initiatives such as the NHSP which is considered a key vehicle for schools to prevent and reduce childhood obesity?

The formulation of these three research questions reflects my current position on obesity for this research activity as one where I am not explicitly attempting to challenge the social construction of obesity as a 'problem' condition, but rather am exploring the challenges that may arise by systems developing

solutions to the perceived problem. A key lesson from the review is that those who attempt to develop alternative perspectives on health and weight to the hegemonic discourse of obesity as a 'problem' will find it very difficult. As Evans and colleagues (2008) appear to point out that one 'one is positioned either on the side of righteousness (the business of making more people thin) or against it, there is no in between. Then there are those advocates within academic psychology who argue a separatist position where it is important to uncouple the condition of obesity from the person (Brownell, 2005). Here one can have a social justice agenda to ensure compassion, empathy and respect to individuals and still fight obesity as an undesirable and dangerous condition.

Although Brownell's (2005) perspective challenges the legitimisation and self determination of fat-identities, for the purposes of this study it is an informative aspect in the development of my methodology that is shared in the next chapter. In light of the social and political complexities of my proposed research, potential stakeholders and participants for research might find a similar 'separation' more acceptable and than an approach that might challenge whether obesity should be construed as a problem condition. The decision to employ a methodology that entailed exploratory, rather than explanatory methods gave opportunities for reflexivity that would allow me to reflect further on my position and discover whether I could have integrity occupying this middle ground.

# **CHAPTER 3: METHODOLOGY PART ONE CONCEPTUAL FRAMEWORKS UNDERPINNING THE STUDY**

**“The purpose of qualitative research is often not so much ‘truth’ telling as it is story re-presenting”**

**[Sikes 2000 p267]**

## **3.1 Overview**

The broad aim of this study was to gain some understanding of the varied perspectives of key stakeholders, including children and young people, regarding how the psychosocial correlates of childhood obesity were being considered within National Healthy Schools Programme (NHSP) initiatives being carried out in an Extended Services Cluster (ESC). The ESC was situated within the Local Authority (LA) where I am employed as an educational psychologist (EP).

This series of three interrelated methodology chapters provides the rationale that led to the use of a research design informed by a pragmatic paradigm that primarily entailed the use of qualitative research methods for data collection and analysis. This first chapter (Part 1) ‘Conceptual Frameworks’ looks at the themes listed below:

- philosophical considerations;
- the role of the literature review;

- reflexivity;
- ethics;
- the role of children and young people in research;
- researching sensitive topics;
- the role of theory; and
- reliability and validity.

The next chapter (Methodology Part 2) provides an account of the espoused and enacted design and methods through the planned stages of the research. The final chapter in the series, (Part 3), provides an overview of the chosen methods of analysis used in the study and develops conclusions from this series of methodology chapters.

### **3.2 Philosophical considerations**

Available methodologies are diverse, reflecting their implicit or explicit understanding of ways of knowing (epistemology) and the reality they seek to know (ontology) (Pring, 2000; Nightingale and Neilands, 1997). There are two major paradigms in research, positivism/post-positivism (empirical/quantitative research) and interpretivism (constructivist/qualitative research). As an EP these paradigms have been highly influential with regard to my experiences of using and carrying out research. The discipline of psychology has traditionally been skewed towards a positivist orientation (Symon et al., 2000), whilst educational research has a more intimate relationship with interpretative approaches (Torgerson and

Togerson, 2001). However, such a simplistic dichotomy does not reflect the scope and eclectic use of approaches undertaken in psychological, educational and educational psychology research (Fox, 2003; Willig, 2001; Cohen et al., 2000).

Fox (2002) claims EPs are moving away from the hitherto dominant positivist positions towards more constructionist perspective. He argues that this most likely creates tensions within a climate that promotes EPs' and Educational Psychology Services' (EPSs) practices as striving to reach 'gold standard' research/evidence-based practice in the hierarchical framework for 'quality' research (Frederickson, 2002). The emphasis on 'gold standard' reliability and claims of 'methodolatry' can be seen as part of the wider debate about the utility of educational research and the appropriate methodology and methods that should be used in psychological research (Chamberlain, 2000; Edwards, 2000).

Brown and Stega (2005) state that adopting new approaches to research is difficult and challenging given the extent to which we have all internalised dominant ideas about what constitutes "good" research" and "acceptable" research practices. For this research activity, despite my seasoned positivist inclinations, I saw the need to embrace and learn within another community of research practice (Hodkinson, 2004). I saw interpretative approaches being the most appropriate as I am:

- concerned with meaning – how people make sense of the world and how they experience events;

- concerned with the quality and texture of experience rather than with the identification of cause-effect relationships;
- opposed to predicting variables and 'imposing' preconceived variables; and
- conducting my research in open systems naturalistic environments.

(Adapted from Willig, 2001)

I believe my account of my choice of methodology is not based upon debating and acting on the status, merit and influence of two paradigms but three. My personal values and beliefs have led me to have some embryonic interest in the field of 'critical psychology' (Prillentsky and Fox, 1997). Critical psychology emphasizes social justice and human welfare. This field of interest is situated within what is known as an emancipatory paradigm.

The emancipatory paradigm is an epistemological stance that challenges the two major paradigm positions with regard to the values and purposes of the researcher, the researched and research activity. Here the goal of research is to advance knowledge in order to create social change for the benefit of the marginalized. Research is value-driven and attuned to issues of power. Research is done 'with' the disadvantaged not 'on' them (Prilleltensky and Nelson 2002).

My reading and reflections on the literature led me to conclude that I did not have to make a choice between these three paradigms in carrying out the research. My methodology could be indicative of a fourth 'pragmatic' paradigm that allowed me to embrace, and be informed by, mixed and multiple philosophical approaches

and research methods, if needed. Robson (2002) argues that this pragmatic approach is akin to the 'critical realism' approach he proposes. The pragmatic approach could be defined as using what works for the research purposes. The tension between the paradigms can be managed in order to achieve this end (Robson, 2002). In fact some commentators hold the view that false dichotomies have been created in philosophical debates within research. Real life cannot be captured by one and there needs to be integration and overlapping of paradigms (Avis, 2003; Pring, 2002).

In order to draw together and reflect what a pragmatic approach could entail, I adapted Mertens' (1998) useful table of epistemological, ontological and methodological features of empirical, constructivist and emancipatory research. As seen in Table 3.1, I included the views of the nature of a pragmatic/critical realist paradigm from other commentators (Robson, 2002; Cohen et al., 2000; Tashakkori and Teddie, 1998). There was also recognition that the literature review undertaken would be a key resource to identify the epistemological and ontological orientations of the researchers through the language, methods and tools used. In turn this would have a significant influence in informing and shaping my own methodology.

### **3.3 The role of the literature review**

The literature review was not just a means to inform research questions in an area



of interest, but to gain insight into the nature and scope of research designs used to elicit past findings and the paradigms used to inform these. This in turn would help my own methodological decisions. In light of this, the critical analysis of the reviewed articles indicated that research activity on the psychosocial correlates of childhood obesity was mainly positivist in orientation. The researchers were looking for relationships and patterns between psychosocial outcomes and weight status with sample groups to generalise to the whole populations. In fact there was little explicit reference to any epistemological or ontological positions in the published articles reviewed. Although this could simply indicate that such debates are reserved for a thesis rather than journal publications, it can also be argued that such omissions are simply reflective of a taken for granted unproblematic positivist stance: an assumption that there is no need to consider and debate alternative ontological and epistemological positions as there is no other reality and no other ways to know it (Usher, 1996).

The language used by commentators and researchers also indicates their epistemological and ontological orientations. Words such as 'hypothesised' (Griffiths et al. 2006), 'univariate analyses' (Sweeting et al., 2005) and 'cohort studies' (Viner and Cole, 2005) suggest empirical points of reference. Subjective positioning within articles with the use of 'We' (Evans et al., 2005) and 'I' (Crossley, 2004) were key markers for those researchers with interpretative leanings.

**Table 3.1: Summary of the four key paradigms (developed from Cohen et al., 2002; Prilleltensky and Nelson, 2002; Robson, 2002; Mertens 1998,; Tashakkori and Teddie, 1998)**

<b>Basic Beliefs</b>	<b>Positivism/Post Positivism</b>	<b>Interpretative/ Constructivist</b>	<b>Emancipatory</b>	<b>Pragmatic</b>
<b>Ontology (nature of reality)</b>	One reality; Facts an objective reality knowable within specified parameters of probability.	Multiple, socially constructed realities. A subjective reality. Values	Multiple realities shaped by social political, cultural, economic, ethnic, gender and disability values	Multiple, subjective, socially construed realities.
<b>Epistemology (nature of knowledge; relation between knower and would be known)</b>	Objectivity is important; researcher manipulates and observes in dispassionate and objective manner. 'Scientism'. Unreflexive. Knowledge formation is linear and cumulative.	Interactive link between researcher and participants; values are made explicit; created findings.  Humans react to knowing that they are being studied, the nature of knowledge can be changed.  Anti-scientism	Interactive link between researcher and participants; knowledge is socially and historically situated.	An objective or subjective point of view may be held by the researcher whilst conducting quantitative and qualitative studies respectively
<b>Methodology (approach to systematic enquiry)</b>	Quantitative (primarily); interventionist; decontextualised.	Qualitative (primarily); dialectical; Contextual factors are described.	More emphasis on qualitative (dialogic) but quantitative design could be used. Contextual and historical factors are described especially as they relate to oppression.	Qualitative, quantitative, mixed or multiple methods.

As illustrated, identifying the objectivity or subjectivity of researchers is another means to distinguish differing epistemological stances. Positivist researchers seek objectivity to try to eliminate bias. Researchers within interpretive traditions recognise and acknowledge the complex and recursive interplay between variables as integral to social realities and seek to describe, it rather than control for these or to position them as sources of bias. The researchers in the childhood obesity studies generally took an objectivist stance. There was a clear distinction and separation between themselves and the respondents and the data they reported. This was achieved by the research methods; often enough, surveys and questionnaires were positioned and acknowledged as the only instrument or communication medium between researcher and researched. This stance can be seen as problematic and somewhat illusory. For example there were no explicit references to how researchers' own beliefs and attitudes toward obesity would affect their research, even within those studies that investigated weight bias and stigma. Researchers' subjectivity was eliminated as a factor influencing the knowledge claim (Usher, 1996).

The use of traditional qualitative methods such as interviews to elicit the views of participants is also evident in the review of the literature (for example Curtis, 2008). It could be argued the motive to gain some insight into what people feel or believe about something through self-report is suggestive of an interpretive enquiry. However those who adopt an interpretive paradigm could argue that case study, life history, or ethnographic approaches are more rigorous and appropriate methods to gain such insight (Robson, 2002).

The research that has been undertaken on weight stigma (e.g. Latner et al., 2007, Neumark-Sztanier et al., 2002) could be seen as evidence of an emancipatory approach adopted by researchers. The research and associated commentary are explicit about the agenda in raising awareness of the nature of weight bias/stigma and the social and political-cultural forces that underpin it and inform recommendations for social change. However for those engaged in emancipatory approaches it may not go far enough. In particular the participants' self-determination and democratic participation in the research project are not always fostered (Brown and Stega, 2005).

Although some researchers investigating psychosocial correlates have used quantitative and qualitative methods in the research process, there is no explicit reference to the use of a 'pragmatic approach'. I was able to locate only one doctoral study that claimed a pragmatic approach to the research within which two studies, one quantitative and the other qualitative, were carried out simultaneously (Foster, 2004). However even with this study there was the question of whether the use of mixed methods did denote a pragmatic paradigm or as Giddings (2006) argues, not a methodological paradigm but a pragmatic research approach that acts as a cover for the 'continuing hegemony of positivism' where the 'thinking' of positivism continues in the 'thinking' of mixed methods'. Giddings (2006) further argues for a more inclusive mixed methods approach that could be addressed by developing and utilising multi-methodological co-operative inquiry frameworks involving researchers of varied paradigmatic positions.

As a lone researcher, I saw the main mechanisms to demonstrate practice of a pragmatic methodology was in the nature of the reflexivity in which I engaged, and the decisions made about priorities with regard to the nature of the ethical challenges that arose from my research experiences.

### **3.4 Reflexivity**

Arber (2006) describes reflexivity as the capacity to reflect upon one's actions and values during the research, when producing data and writing accounts, and to view the beliefs we hold in the same way that we view the beliefs of others. Malterud (2001) states that reflexivity starts by identifying preconceptions brought into the project by the researcher. These include previous personal and professional experiences, pre-study beliefs about how things are and what is to be investigated, motivation and qualifications for exploration of the field, and perspectives and theoretical foundations related to education and interests. Willig (2001) also argues that researchers should reflect upon their own standpoint in relation to the phenomena they are studying to attempt to identify the ways in which such a standpoint has shaped the research process and findings.

In this study I considered that my own professional and personal identities in the research activity would interact with the research process. With regard to the professional identities, I have already highlighted how the use of a pragmatic paradigm could provide a framework to allow exploration within

different paradigmatic positions through the course of study with regard to my identity as a researcher. In addition to this I also needed to consider the potential dynamics and impact of my identity as a practitioner in positioning, negotiating and working as a researcher in a setting where I work routinely as an EP.

The Extended Services Cluster where I conducted my research is a setting where I have an established professional role as an EP. Although I have carried out development activities in individual schools and have given support to evaluation activities within the cluster, this was my first engagement within the setting with an explicit personal professional development agenda i.e. undertaking postgraduate research toward a higher degree. However my key concern was how those dual roles in the cluster would facilitate or inhibit the research activity. For example on the one hand the perceived view of mutual professional respect and trust could facilitate access and engagement with participants in the setting. On the other the dual role could generate conflicts of interest that could lead to my own professional or research role being compromised.

Although this was not an ethnographic study, I found articles on ethnographic approaches informative in making sense of these dynamics. As Warren (2001, p203), cited by Harrington (2003), observes, “the fieldworker is the research instrument” who negotiates but cannot fully control his or her social placement within the field. My reflections about the processes of negotiation and engagement with participants, my changing positions and meta-positions

within the setting would reveal some aspects of the journey as it moved from the planned to the enacted research design.

On a personal level, a fat identity has characterised my personal life since childhood. Bridges (2001) argues that while individuals from within a community may have access to a particular kind of understanding of their experience, (although it might attach special interest to their representations of that experience) this does not automatically attach special authority. I am conscious of the potential charges of bias because of my 'special' interest. There also had to be an acknowledgement that as an obese person, I am an evident visible representation of the 'problem' that was being researched, and that this would be likely to have an impact on the engagement and responses of participants. Studies have shown how researcher characteristics may influence the responses of the participants being studied to the extent that the participants both perceive particular characteristic(s) and either consciously or subconsciously deem these characteristics to be relevant to the question(s) being asked or to the action(s) being performed (Miyazaki and Taylor, 2008). Clandinin and Connelly (1994) have cautioned about the researcher becoming a character in the story being told, and that as a result the story will change.

In light of these professional and personal interplays, there was a need to ensure regular monitoring so that my voice and my values and beliefs and personal experiences would not dominate or influence the voices of those I was trying to enable. This required a level of regular self-reflexivity during the

research process. My fieldwork notes were the key vehicle to 'reconstruct' research experiences. A key method was the use of a contact summary form, adapted from Miles and Huberman (1994) (see Appendix 3.1), that was completed after every research contact in the field. The original version was formulated to provide an overall summary of the main points arising in the contact . In addition, reflexivity was aided by the use and reference to additional general 'diary' notes taken throughout the fieldwork and analysis stages. Regular supervision with tutors also played a key role in discussing and informing my reflections and the supervision records were utilised as an additional source of record of diary record.

### **3.5 Ethics**

Guillemin and Gillam (2004) suggest that there are three dimensions of ethics in all research:

- a) procedural ethics, which usually involve seeking approval from a relevant ethics committee;
- b) "ethics in practice" or the everyday issues that arise in the doing of research; and
- c) research ethics as articulated in professional codes and codes of conduct.



It is argued here that the last dimension, 'codes of conduct' needs to be considered first. These codes relate to my over-arching identity as a practising psychologist and researcher. The codes provide the super-ordinate responsibility/framework within which the other two dimensions are addressed.

### **3.5.1 Codes of Conduct**

As a psychologist, thinking about ethics should pervade all professional activity, including research (BPS, 2006). In considering research governance, all the steps in my research should reflect the Code of Ethics of the British Psychological Society (BPS, 2006) and the Health Professionals Council (HPC, 2006). I also needed to take into account the Revised Ethical Guidelines for Educational Research published by the British Educational Research Association (BERA, 2004).

The main challenges as I saw them were:

- working with children and young people;
  - researching a sensitive topic; and
  - carrying out a research activity that could result in the very phenomenon of 'unintended harm' that was one focus of my research.
- Gott (2003) argues that identifying any vulnerable individual or groups carries its own risks and may be counterproductive to inclusion.

These challenges are interrelated and are explored in more detail with others below when the enacted fieldwork data collection stages are described. All the challenges had to be addressed when seeking approval from the Ethics Committee within the University.

### **3.5.2 Procedural ethics**

The relevant Ethics Committee was the academic department where I was registered as a research student. Although Guillemin and Gillam (2004) initially argue that the process of diligently completing and submitting a jargon-free 'ethics-committee speak' application form, is a formality and a hurdle to surmount in order to get on and do the research, I saw it as a useful process to prepare me for the key challenges identified and to help shape my responses for my 'ethics in practice'. The ethics form (see Appendix 3.2), alongside the initial research proposal (Appendix 1.1) helped to ensure that the following considerations were articulated and addressed with regard to the following key aspects of the research:

- Recruitment of participants
- Consent
- Withdrawal
- Confidentiality
- Detrimental effects
- Storage and handling of data
- Harmful or illegal behaviour

- Subterfuge
- Dissemination of findings.

(taken from Form EC2 School of Education University of Birmingham)

Table 3.2 overleaf provides a summary of the plan of action that was used to address these matters. The sections on the planned and enacted design within the fieldwork data collection stages outline how these requirements were resolved. Formal approval was gained as indicated in Appendix 3.3.

### **3.5.3 Ethics in Practice**

In general, reflexivity and supervision were the key tools in the ongoing monitoring of these ethical considerations in my research practice. The ethical and operational challenges that arose did lead to adaptations to the research design and methods as will be illustrated below; for example dealing with the problems that arose with the withdrawal of participants. Also the research journey highlighted how I could underestimate the need for ethical vigilance to ensure care for the role of the researcher as well as towards the participants in the study; for example, managing the tensions of multiple identities within the study.

**Table 3.2 Main Ethical Considerations for Research**

<i>Aspects</i>	Steps taken to ensure defensible practice
Recruitment of participants	<p><b>Adults</b> Write to key stakeholders in the delivering of provision with an EPSC e.g. Steering Group, multi-agency providers, Heads and Governing Bodies of schools, NHS practitioners, voluntary agencies. Use of a steering group meeting as an initial consultation event. Possibility of using the regular multi-agency group and steering group meetings as a consultation event. When named persons have been identified for interviews, write to request participation in project.</p> <p><b>Children</b> – Use of advisory reference groups of children and young people (CYP) to explore ways to facilitate children and young people's engagement in the research. Open recruitment via schools and parents.</p>
Consent	Voluntary and informed consent. Chains or hierarchies of consent will be particularly considered with work with CYP. Agreement from Heads and parent/carer/s as well as the CYP themselves. Consideration of Ladder of Participation model (NSPCC 1997)
Withdrawal	Rights to withdraw from study made explicit and communicated effectively with written and verbal communication. Need to take account of power dynamics in children and adult roles. Need to ensure that activities with CYP that take place in school settings take account of culture and positioning of children where rights of withdrawal will only have been practised subversively or would not in most cases be construed as such by CYP.
Confidentiality	Confidentiality and anonymity of participants ensured by removing any personal references to names and community focus groups.
Detrimental effects	Obesity may be an emotional difficult subject for participant as well as researcher. Ensure participants have access to debrief/aftercare after interviews. Researcher to use formal and informal support in the form of tutor and peer supervision.
Storage and handling of data	Adhere to Local Authority's data protection guidelines. Storage files and boxes of documents, transcripts and recordings marked confidential. Destroy unwanted copies.
Harmful or illegal behaviour	Ensure interviews take place in negotiated safe spaces within school and community settings for both the researcher and participants. Researcher is subject to an enhanced CRB clearance. Ensure any adult research partner subject that might support focus groups or interviews have required CRB clearance. Adhere to Child Protection Policies.
Subterfuge	I do not envisage any research activity will be undisclosed. There will be a need to ensure that participants recognise that the study will entail challenges. E.g. provision for prevention and management of obesity may have the intent of promoting well-being but in fact may be undermining it.
Dissemination of findings.	Written reports to ESC and schools. Summary of findings to children research participants.

### **3.6 The role of children and young people in research**

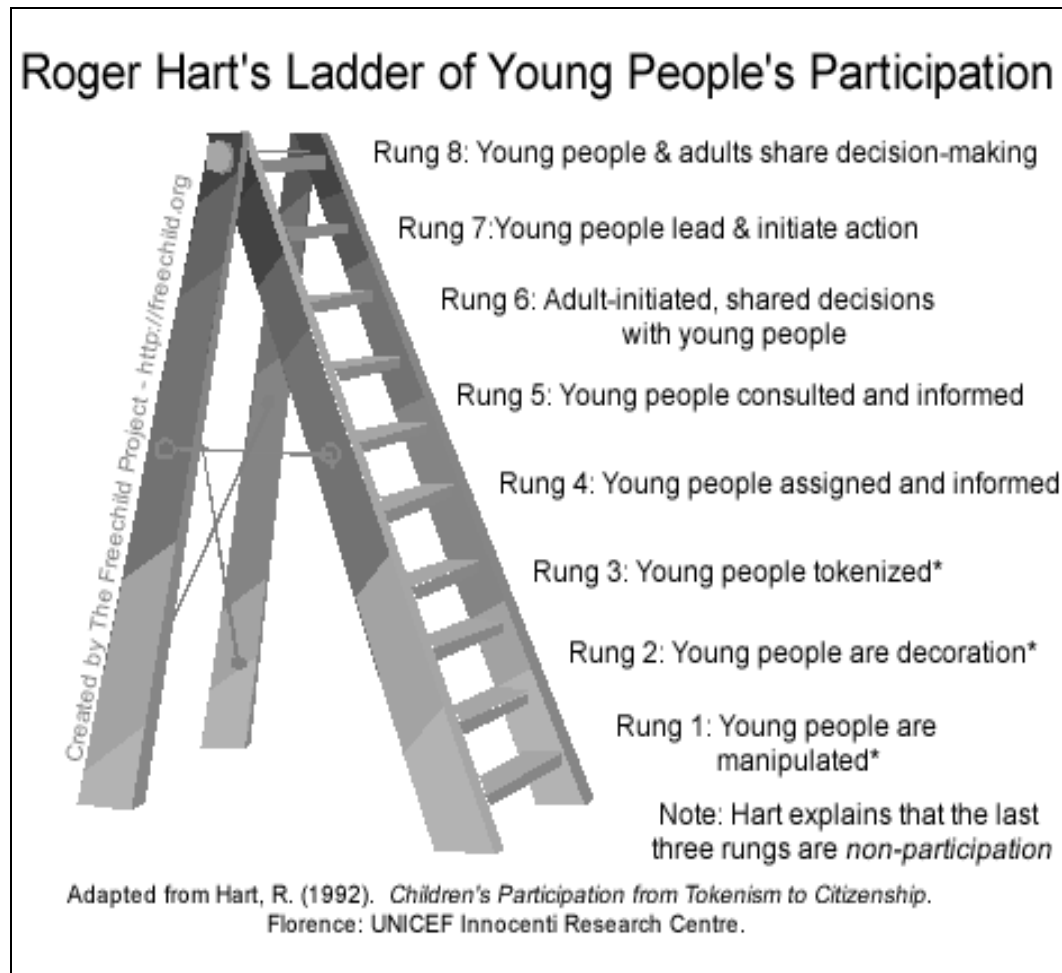
Key challenges with regard to the traditional representations of children's competence to make decisions to participate and provide valid data, as well as the differential power relationships between children and adults in the research process needed to be mediated within my study (Alderson, 2005). Articles 12 and 13 of the UN Convention on the Rights of the Child, (UN, 1989), promotes a rights-based approach to pupil participation. Roger Hart's (1997) Ladder of Participation, illustrated in Figure 3.1 overleaf, is advocated as a useful framework to inform research approaches with children and young people; to understand and distinguish between different levels of empowerment afforded to children (Whitty and Wisby, 2007). Shier (2001) points out those different levels may be appropriate for different tasks as part of an activity, project or organisation.

I considered that there were three main ways that the research study would reflect sound ethical research with children. On a general level there was the need to address the specific rights and needs associated with the ethical considerations listed in Table 3.2 (p103), such as seeking informed consent and ensuring best outcomes by avoiding or reducing detrimental effects.

The second way was finding mechanisms to enhance the level of active participation of children and young people in the research process. I wanted to achieve a minimum of 'Rung 5' on Hart's ladder of participation where young people are consulted and informed. I therefore set up children and young

people advisory references groups as a vehicle to operationalise the emancipatory tenets I wanted to establish in this research. Advisory reference groups aim to include as co-researchers people who are involved in the contexts under scrutiny (Lewis et al., 2008; Porter et al., 2006).

**Figure 3.1 Hart's (1997) Ladder of Participation Model**



Source - [www.freechild.org/ladder.htm](http://www.freechild.org/ladder.htm)

Thirdly, through the design of the study I sought to ensure effective engagement of children and young people through face to face interactive contact and approaches. Darbyshire and colleagues (2005) concluded from their Australian obesity-focused qualitative studies that using multiple

methods in researching children's experiences is a valuable approach that does not merely duplicate data but also offers complementary insights and understandings that may be difficult to access through reliance on a single method of data collection.

### **3.7 Researching Sensitive Topics**

Obesity and weight stigma are considered sensitive topics for discussion in prevention and management approaches for weight status and weight stigma (Perrin et al., 2007; Puhl and Latner, 2007). However there appears to be an absence of commentary as to whether as a focus topic in research, researchers are carrying out 'sensitive research' as opposed to the research activity involving the discussion of sensitive topics (e.g. Curtis, 2008).

Sieber and Stanley (198 p49) define socially sensitive research as 'studies in which there are potential consequences or implications, either directly for the participants in the research or for the class of individuals represented by the research'. This definition is broad in scope and could allow for the inclusion of obesity research that involves participants and researchers engaged in an area that some may find sensitive. However the definition could be too broad and one could argue that by this definition all research is sensitive and that potential concerns should be addressed through the generic ethical requirements for research.

Lee (1993) cited by Dickinson-Swift and colleagues (2008 p2), suggested 'sensitive topics' can be made more distinct to include areas which are seen

as threatening for three reasons: the first is a result of intrusion into private, stressful or sacred domain; the second is the threat of sanctions that may expose stigmatising or incriminating information; thirdly, sensitivity may reside in political threats, resulting from vested interests.

My research had the potential to enter into all three domains. The research questions and methods were likely to enter into territories of privacy with regard to personal experiences with obesity and weight-related issues for participants as well as myself. With regard to a threat of sanctions, as the research would elicit views on childhood obesity weight stigma, attitudes and practices could be revealed which participants would be likely to view with potential embarrassment and/or loss of personal and/or professional integrity. With regard to political threat, the research activity could potentially generate a critique counter to the government 'flagship' policy on the role of schools within the childhood obesity agenda through the National Healthy Schools Programme.

My priority concern was to ensure minimal risk of intrusive threats. I felt that if I was committed and adhered to the ethical guidelines with regard to confidentiality and containment of potential detrimental effects, and ensured ongoing reflexivity, then such risks would be minimized. Reflexivity would also be used as a tool to address dilemmas in other threatening areas, as some of the issues surrounding sensitive research are not always apparent at the outset of the research. Researchers often cannot predict how they or the



participants will be affected; they often do not know in advance what may come out of the research (Dickinson-Swift et al., 2007).

For example through the research process I had to take on board and deal with Herzberger's (1993) claim that sensitive topics have tended to inhibit adequate conceptualisation and measurement of research instruments. This will be highlighted below in the overview of the research design and methods. A level of sensitivity was evident and contributed to difficulties in eliciting quality data. This led to revisions to the design and tools and in the fieldwork data collection phase of the. In general a key learning point in the study was how research on sensitive topics revealed new insights into, and sharpening of ethical dilemmas in research (Dickinson-Swift et al., 2008).

### **3.8 The Role of Theory**

Silverman (1993) (cited by Willig 2001 p9) argues that without theory there is nothing to research. Robson (2002) appears to support this view by saying that lack of theory is a feature of unsuccessful research. Without theory the research may be easier and quicker but the outcome will often be of little value. With the exception of studies explicitly looking at weight stigma, research studies on the psychosocial consequences of obesity have typically focused on determining the nature and strength of the causal or correlational relationship between weight status and psychosocial outcomes. It could be argued that because of the studies' positivist orientations, the purpose of

these studies was theory verification about the risk of negative psychosocial consequences for children and young people who are overweight/obese, rather than theory generation. However, the weight stigma studies have attempted to test theories such as attribution and social learning theory (e.g. Puhl and Brownell 2003a) and develop conceptual frameworks (Brownell, 2005) to explain and predict the nature and impact of weight stigma.

I envisaged that ideas and theories would be generated through the research process, rather than having a definitive view about a theory to be tested. Initially I adopted a simplistic perspective that I would be engaging in something akin to a grounded theory approach. Grounded theory develops from theoretical analysis of data, and has relevance to the area of study (Charmaz 2003). However Charmaz (2003) argues that researchers who claim to develop grounded theory actually only provide conceptual analyses of a particular experience instead of creating a substantive or formal theory.

Such considerations created some anxiety that my search for a plausible theory to demonstrate my understanding of the experiential data gained would end in nothing. Therefore I decided to take heed of Robson's (2002) advice that if there is a serviceable theory relevant to one's proposed study, it would be sensible to test its utility.

I decided to use the 'ecological-transactional' (ET) model offered by Lynch and Cicchetti (1998) and developed further by Cicchetti and colleagues (2000) as an initial framework to guide the research process. The ET model was

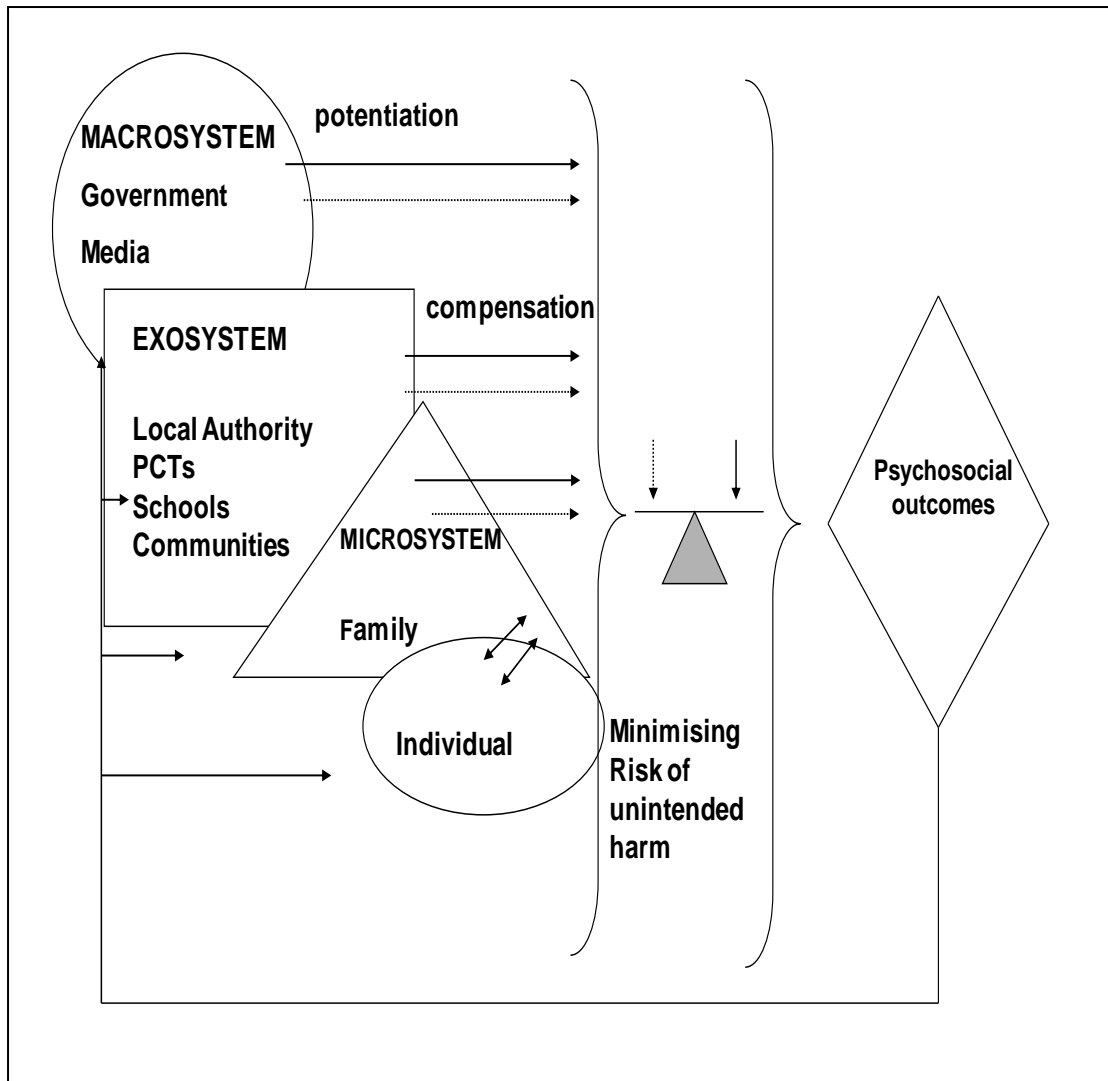
elaborated in the Literature Review chapter (p69-70) where the focus was on how the model could account for individual differences in psychosocial outcomes of childhood obesity.

The purpose of this study is not concerned with outcome prediction or theory testing. As illustrated by Figure 3.2 below, I saw the model as a useful conceptual framework to guide my bottom-up approach and interpretation of the social ecology surrounding the childhood obesity agenda in the cluster under scrutiny and its impact on psychosocial outcomes for children and young people where weight status is a cause of concern.

A key advantage is that unlike other ecological models, the ET model highlights more graphically the impact of risk potentiating and compensatory factors arising from the transactions within the nested systems on potential outcomes. As the study was exploring the notion of unintended harm and how to minimise such risk, I saw the ET model relating directly to the purposes of the study.

It was also important within the research to identify and acknowledge the limits of the model. In light of the context I was exploring, the immediate drawback was how the systems should be defined. Bronfenbrenner (1979), in his original ecological systems theory saw school and community contexts equally as microsystems rather than being incorporated into the exosystem as positioned by Cichetti's and colleagues' (2000) ET model.

**Figure 3.2 Use of the Ecological-Transactional Model (EST) (adapted from Cicchetti et al 2000) to map factors from childhood obesity prevention and management approaches and their wider impact on psychosocial outcomes for children and young people**



It is the interconnections that develop between the microsystems via the active participation of the child and the bi-directional links made between the microsystems, which form the basis of the existence of a mesosystem (Bronfenbrenner 1979). This level of analysis and explanation is not represented in the ET model. Within the local authority where I work, extended services are delivered using a cluster model so schools and partners in a particular geographical area work together to deliver the

extended services core offer. I considered these microsystemic partners, through their collaboration within the cluster, could be seen as operating as a mesosystem as shown by Figure 3.3 overleaf.

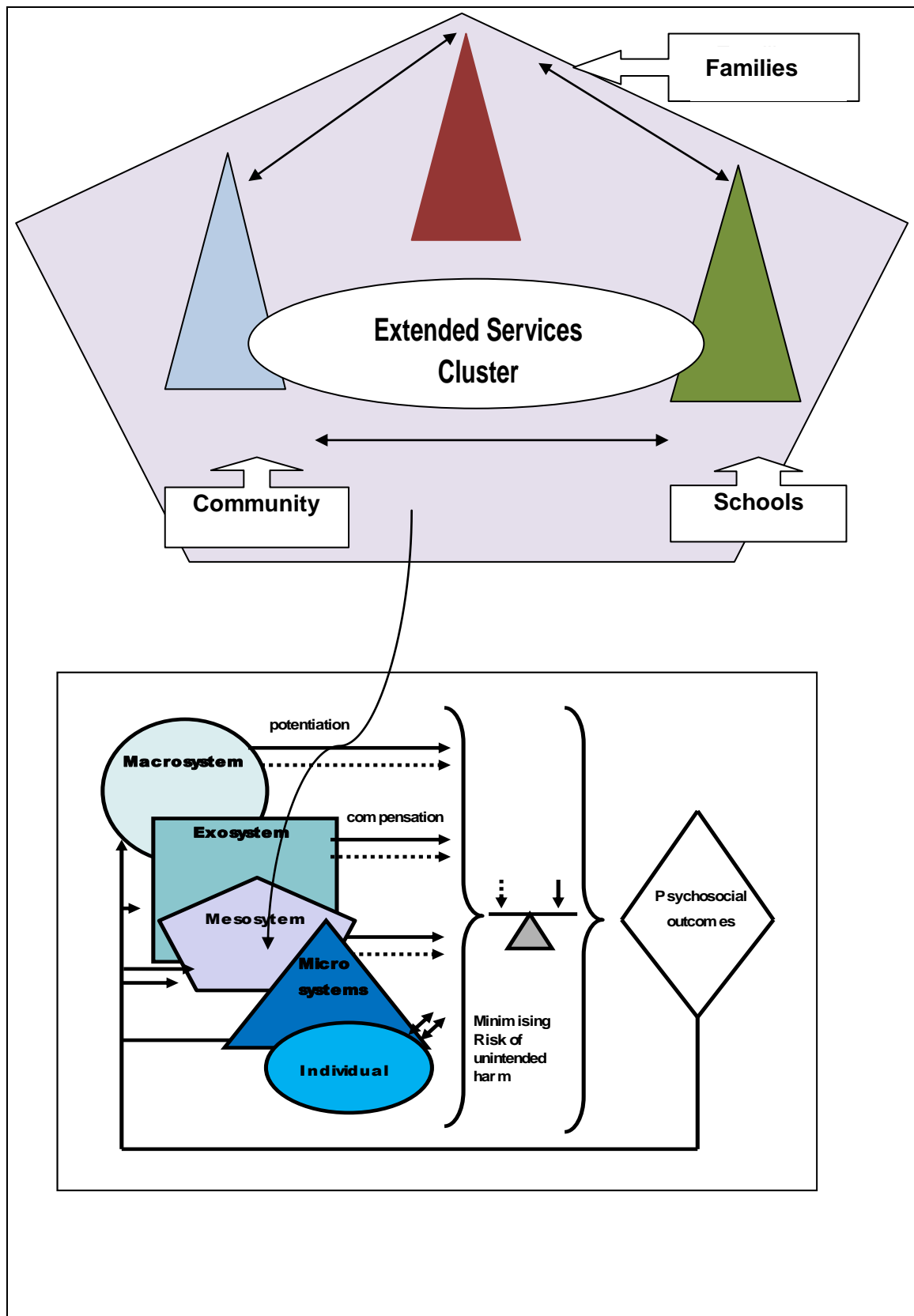
Another potential criticism of my use of the ET model is the lack of attention at the ontogenic level during the study. Although my focus was on seeking perspectives at the higher systemic levels it would be important to acknowledge the range of ontogenetic factors that can contribute to outcomes. This aspect was revisited in the discussion of the analysis of the data below.

The other key consideration was that in light of the sensitive nature of the research, the use of a model that has been linked to research and debate on child maltreatment and the role of community violence (Cicchetti and Lynch, 1993, Overstreet and Mazza, 2003), might be seen by some under academic scrutiny as somewhat alarmist and threatening for a scenario of a well-intentioned national and local government health promotion agenda.

Prilleltensky and Nelson (2002) also raise caution that within the emancipatory paradigm, there is the acknowledgment that theories can have the capacity to normalize the oppressive context that has led to the phenomena that form the focus of investigation .

Overall taking into account these potential disadvantages; I still felt an amended ET model would be a useful conceptual framework to guide the

**Figure 3.3 An Extended Service Cluster operating as a mesosystem within an ET Model**



creation of a contextually rich picture through the collection and mapping of data.

### **3.9 Reliability and Validity**

This research study needed to be credible, actionable and trustworthy (Potts and Brown, 2003). The diverse paradigms that influenced the design of the study have varied views on reliability and validity. Independent replication is the key mechanism of assuring reliability and validity in positivist empirical research. Collingridge and Gantt (2008) argue that reliability and validity in qualitative research typically refer to adopting research methods that are accepted by the research community as legitimate ways of collecting and analyzing data. Unlike positivist drivers, the focus is not on using the appropriate tools to obtain exactly the same results time and again but rather on achieving consistency and similarity in the quality of the results.

With regard to generalizability, qualitative researchers need to consider 'analytic or theoretical generalization' (Robson 2002). Researchers' accounts should provide clear links to existing theory and research and provide rich descriptions of the context to allow readers to make informed judgements regarding the applicability to other contexts. Morse (1999) argues knowledge gained in qualitative studies is not limited to demographic variables; it is the fit of the topic or the comparability of the problem that is of concern.

Yardley (2000) has offered three broad principles for assisting the quality of qualitative psychological research:

- sensitivity to the context;
- commitment, rigour, transparency and coherence; and
- impact and importance.

I felt my practitioner experience had provided an informed knowledge and therefore sensitivity to the context that was the focus for exploration. I also felt that there was another level of sensitivity through my informed knowledge through the literature review, of the topic under investigation. For this research the commitment, rigour, transparency and coherence would be addressed through the robustness of my design and the use of triangulation and audit trails which would reduce threats to validity and reliability (Robson 2002). Triangulation involves the use of multiple sources to enhance the rigour of research (Denzin, 1989). An audit trail entails a record of activities undertaken while carrying out the study. For my own research, the research design, the raw data, the research notes and details of the coding and data analysis, will be important components continuity to the trustworthiness of my findings.

As a consequence of these methodological considerations, the research design was developed. The planned and enacted designs are described in the following chapter.



## **CHAPTER 4: METHODOLOGY PART TWO THE PLANNED AND ENACTED RESEARCH DESIGN AND METHODS**

**“The research process is never as linear as it is portrayed... the process can be very interactive in nature... a researcher may be doing footwork that more resembles the cha-cha than a straightforward stroll”**

**[Mertens and McLaughlin 1995 p14]**

### **4.1 Introduction**

As this study was heavily influenced by interpretive approaches, it is important to be open about the fluidity and changes to the design throughout the research process through sharing the story of what I wanted to happen and what did happen. These accounts will also highlight key ethical and operational challenges that arose as the study progressed, and how these were addressed.

### **4.2 A case study design**

The major feature of the research design was its conceptualisation as an exploratory case study. A case study is defined as an in-depth description and analysis of a bounded system (Merriam, 2005). For the purposes of this research the nature of the bounded system was demarcated by the research questions, as the aim was to explore a particular topic within an already existing ecological system, an extended services cluster (ESC) called ‘Westfield’ (*a pseudonym to preserve anonymity*).

As demonstrated earlier in Figure 3.3 (p113) I saw 'Westfield' ESC as a mesosystem that connected key school and community microsystems in an ecological transactional model. My planned research design was primarily focused on collecting data from this mesosystem and the related microsystems. To a lesser extent there was also a need to explore the interactions with the surrounding exosystem as a means to understand how the strategic role of the local authority's city-wide policy and provision on childhood obesity impacted on local provision in the cluster. The literature review had already served as an instrument to collect data at the macrosystemic level through the reading of key statutory documentation and media discourse on childhood obesity.

There were three key reasons for the purposive selection of 'Westfield' for the research study:

1. I had a working relationship within the cluster
2. Although less than ten in number, the schools in the cluster fully reflected the age range of children young people (3-16 years old) in the community, locally and nationally<sup>5</sup>.
3. Obesity targets were part of the cluster's current action plans during the period of study.

I saw these factors facilitating access to and engagement of potential participants in the study.

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<sup>5</sup> To protect anonymity no further specifics will be given with regard to the number and different age phases of schools as this would make the cluster easily identified.

The 'Westfield' cluster is geographically situated within the inner city area of the local authority where I work. Annual ward and primary trust data consistently identify the area as one of the most economically and socially deprived in the city, with high rates of health inequalities<sup>6</sup>.

### **4.3 The design and time frame for the study**

The research design involved six stages:

1. Consultation with key stakeholders
2. Ethics committee approval
3. Choice of methods to operationalise the research questions
4. Fieldwork data collection – the planned and enacted stages
5. Chosen methods of analysis
6. Write up and dissemination to stakeholders and participants

This chapter covers the first four and sixth stages of the design with the remaining stage, 'Chosen Methods of Analysis' summarised in the following chapter (Methodology Part 3).

Table 4.1 below provides a summary of the planned and enacted time frame of the study.

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<sup>6</sup> To protect anonymity no further specifics are given

**Table 4.1: Time frame of research study**

<b>Start Date</b>	<b>Activity</b>	<b>Planned Completion Date</b>	<b>Outcome</b>
<b>October 2007</b>	<b>Consultation with key adult stakeholders to negotiate participation of identified EP/SC.</b>	<b>Feb 2008</b>	<b><i>Achieved Feb 08</i></b>
<b>Sept 2007</b>	<b>Drafting and Completing Ethics Committee Form</b>	<b>June 2008</b>	<b><i>Achieved July 08</i></b>
<b>May 2008</b>	<b>Fieldwork Data Collection</b>	<b>July 2009</b>	<b><i>Achieved November 09</i></b>
<i>May 2008</i>	Document audit from participating schools and key community providers	<i>Dec 2008</i>	<i>Incomplete Terminated July 09</i>
<i>July 2008</i>	Pilot Semi-structured Interview with one school lead professional	<i>July 2008</i>	<i>Achieved July 08</i>
<i>September 2008</i>	Semi-structured Interviews with lead professionals in participating schools (Healthy School Coordinators) and key community and strategic providers e.g. Cluster Coordinator, Sports Centre Manager, Health Education Service	<i>April 2009</i>	<i>Achieved November 09</i>
<i>December 2008</i>	CYP Advisory Reference Groups	<i>April 2009</i>	<i>Achieved March 2009</i>
<i>January 2009</i>	Parent/Carers Focus Groups	<i>Feb 2009</i>	<i>Alternative achieved July 2009</i>
<i>Feb 2009</i>	CYP Focus Groups	<i>April 2009</i>	<i>Achieved July 2009</i>
<i>February 2009</i>	Parent/Carer/s Semi structured interviews	<i>May 2009</i>	<i>Not carried out</i>
<b>May 2009</b>	<b>Analysis of Data</b>	<b>December 2009</b>	<b><i>Achieved February 2010</i></b>
<b>July 2009</b>	<b>Completion and submission of thesis</b>	<b>March 2010</b>	<b><i>August 2010</i></b>
<b>April 2010</b>	<b>Dissemination to Stakeholders</b>	<b>March 2010</b>	<i>Aiming for September 2010</i>

#### **4.4                    Stage 1: Consultation with adult key stakeholders**

Children and young people were not consulted at this stage of the study but within the fieldwork data collection stage (Stage 4). It was not just the case that children were rendered voiceless in the initial stages of the research but also their parents, who were positioned as stakeholders but not necessarily equal partners with other adults in this research (Wolfendale 1999; 1992). The adults identified for this consultation stage were in fact the lead school and cluster personnel and, to a lesser extent, other community partners who support the obesity targets as indicated in the cluster action plan. The consultation with key stakeholders did not have the intent of inviting shared ownership of the research or for stakeholders to become co-researchers. Rather, this phase was concerned with offering the potential of a beneficial outcome in the longer term through informing future service delivery on responding to childhood obesity concerns within the cluster. I acknowledge that this level of researcher autonomy and assumed beneficence could be seen as a contrary to the tenets of an emancipatory research design (Truman et al, 2000).

Consultation with the targeted adult stakeholders was achieved by the following steps.

- Informal discussions with representative key stakeholders in the 'Westfield' cluster to 'sound out' potential interest in the research proposal. These stakeholders were:

- the Cluster Coordinator for 'Westfield'; and
  - two headteachers (one primary and one secondary head).
- Formal invitation to participate. This was achieved by:
    - provision of written information summarising the research proposal and offering an invitation to the headteachers and governing bodies of all the schools in the cluster to participate (See Appendix 4.1);
    - provision of written information summarising the research proposal and an invitation to participate sent to the 'Westfield' cluster steering group via the Cluster Coordinator (See Appendix 4.2); and
    - giving a formal presentation at a steering group meeting of the 'Westfield' cluster.

As a result of this consultation, four schools signalled written agreement to participate at this initial stage: the children's centre/nursery school, two of the primary schools and a secondary school. Three of the schools had achieved the NHSP status and the fourth was working towards achieving accreditation.

#### **4.5 Stage 2 -Ethics Committee Approval**

Ethics approval was gained from the University of Birmingham, School of Education Ethics Committee. The length of this process did impact on the

momentum gained from the preceding consultation stage, as it was another six months before the fieldwork data collection stage could start following those consultations. It is difficult to say whether waiting for ethics approval before starting or completing the stage 1 consultation process would have improved subsequent implementation and outcome of the study, as in different ways, the two processes interacted and informed each other as illustrated by the example below.

As a result of the process in securing ethical approval there was a significant amendment to my original research proposal (Appendix 1.1). A key ethical challenge that had to be addressed was the role and recruitment of children and young people identified as overweight or obese. The literature review of other UK studies had indicated that researchers had access to data on weight status either through using clinical samples (e.g. Griffiths and Page 2008; Murtagh et al 2006; Holt et al 2005) or carrying out universal weight measures with community samples (e.g. Curtis 2008; Gray and Leyland 2008; Griffiths et al 2006). It was clear that the clinical sample route would require complex negotiation with the local primary care trust that would probably require separate ethical approval. In fact for the purposes of this study a community sample was judged more appropriate. There was also the question of whether/how an open recruitment method involving self-selection could be handled sensitively, ensuring no detrimental impact on candidates through the recruitment procedures. I judged that it would be inappropriate to carry out objective measures or exercise my own judgements of weight status to recruit participants who were overweight or obese.

Such considerations along with the subsequent review of Curtis' 2008 published study with overweight and obese young people about the NHSP led to an amended focus, and the decision to elicit the views of children and young in the study via a universal rather than targeted recruitment approach. Subsequently, I was able to claim additional utility for this research in demonstrating how the planned study was to make an original contribution to the current knowledge base and theory development. Curtis' (2008) had explored quite comprehensively the impact of the NHSP on overweight and obese young people's school experiences. The views of their peers had yet to be sought.

It was also important through reflection and supervision to ensure that as the research design evolved, developments to design and implementation did not deviate from the ethical framework that had been formally approved.

#### **4.6 Stage 3: Choice and justification of methods to operationalise the research questions**

The research questions were operationalised by the methods of data collection, outlined in Table 4.2 which also summaries the justification for the choice of methods. The key research instruments used were semi-structured interviews and focus groups using purposive sampling to ensure access to participants who would be information-rich sources to meet the aims of the study (Patton, 1990). The use of documents formed a supplementary method.



**Table 4.2 Research questions and data collection methods**

<b>Research Question</b>	<b>Data sources and methods</b>	<b>Justification</b>
1. What are the approaches that are being promoted by partners, particularly schools, within an Extended Provision Cluster regarding the prevention and management of child and adolescent obesity?	Schools, community providers, strategic leads, parents/carers <ul style="list-style-type: none"><li>• Semi-structured interviews</li><li>• Document audit</li><li>• Focus groups</li></ul>	Analysis of the Westfield's cluster action plan and participating schools NHSP documentation would give an overview of the provision in place and desired outcomes.  Semi-structured interviews would provide accounts and reported experiences of providers about their role and rationale behind approaches
2. Do the shared and differential perspectives on policy and practice indicate how such initiatives serve to address and prevent potential negative psychosocial outcomes?	Schools, community providers, strategic leads, parents/ carers <ul style="list-style-type: none"><li>• Semi-structured interviews</li><li>• Document audit</li><li>• Focus groups</li></ul>	Focus groups and semi-structured interviews with parents would elicit views and experiences of the provision linked to the NHSP
3. What are the experiences and views of children and young people on childhood and adolescent obesity and on the role and impact of initiatives such as the HSP, which is considered a key vehicle for schools to prevent and reduce childhood obesity?	Primary and secondary aged children and young people <ul style="list-style-type: none"><li>• Advisory reference groups</li><li>• Focus groups</li></ul>	Advisory reference and focus groups would enable the voice of children and young people to be heard not only as stakeholders in the NHSP within the cluster, but also as stakeholders in the research.

Interviews and focus groups are popular tools in qualitative studies as they allow effective exploration of views and elicit rich and thick descriptive accounts, rather than seeking to chart occurrences, volumes or size of associations between entities that survey methods produce (Wilkinson, 2003).

Semi-structured approaches to the interviews were adopted as opposed to structured or unstructured interview methods. The flexibility allowed both the participants and myself as the researcher to deviate from question and answer formats in order to pursue an idea or response in more detail (Gill et al., 2008). This semi-structured approach also allowed permissible evolution of the nature and content of the interviews beyond the pilot interview that was negotiated with one of the participating schools.

Focus groups can be seen as an alternative to structured or semi-structured interviews. In reality there are group interviews that use the interaction among participants as a source of data (Vaughn et al., 1996). I saw the focus group as the most appropriate method to engage with children and young people and parents. Murtagh and colleagues' (2006) obesity study with children and young people indicated the option for a focus group was chosen, as children are known to have a greater tendency towards self-disclosure in groups than adult.

The seeking out of documentation as a source of data served two purposes. Not only would analysis give data on the nature of provision, but would also serve as a reference to aid exploration during the interviews. For this study, I positioned the documents as supplementary/secondary rather than primary

sources as I did not plan to subject the documents to an in-depth analysis within any specific analytic framework. Prior (2003) argues that documents offer a rich source to enhance understanding of the content and the context of events in time. Miller and Alvarado (2005) assert that documents are not simply the containers of meaning. The social nature of the production, exchange, and consumption of documents means that they signify “social facts” rather than transparent or consistent representations of social reality (Atkinson & Coffey, 1997, p. 47). This notion became relevant in the research when I tried to make sense of the social processes at play when striving to secure access to documentation.

All the methods of data collection were chosen because of the advantages they offered in enabling the desired outcomes of the research to be realised. However there was also recognition of potential disadvantages that are summarised below in Table 4.3. Despite these disadvantages, I judged that my choice of methods offered the best fit for my research questions, knowledge of context and epistemological stance.

#### **4.7 Stage 4 - Fieldwork data collection stages**

The section below first describes the planned/espoused design of the study before moving on to a description of the enacted design. The main

**Table 4.3 Summary of advantages and disadvantages of research methods used in study**

<b>Method</b>	<b>Advantages</b>	<b>Disadvantages</b>
<b>Semi –structured interviews</b>  Smith 2003 Willig 2003 Robson 2002	<i>High validity</i>  <i>Positive rapport with interviewer and interviewee</i>  <i>Able to expand on points (both interviewer and participant)</i>  <i>Able to follow new ideas as they come up</i>  <i>Able to clarify any confusing terms</i>	<i>Reliant on skill of interviewer</i>  <i>Time consuming – conducting, transcribing and analysing</i>  <i>Low reliability-no certainty that interviewees are asked same questions to achieve purposes of study</i>
<b>Focus groups</b>  Gibson 2007 Morgan et al 2002 Punch 2002 Horner 2000 Kennedy et al 2000 Vaughan et al 1996	<i>Able to interact with participants, pose follow up questions or ask questions that probe more deeply</i>  <i>Collects opinions of a reasonable number of participants in a shorter period compared to a series of individual interviews</i>	<i>Time consuming – conducting, transcribing and analysing</i>  <i>Small sample sizes mean the groups might not be a good representation of the targeted population</i>  <i>Group discussions can be difficult to steer and control, so time could be lost to irrelevant topics</i>  <i>Respondents may feel peer pressure to give similar answers to questions</i>  <i>Moderator and setting effects can affect responses</i>
<b>Advisory Reference Groups</b>  Lewis et al 2002 Porter et al 2006	<i>As focus groups above</i>  <i>Emancipatory and participatory principles enable participant stakeholders as co-researchers</i>	<i>As focus groups above</i>  <i>Disparity of gain in role of co-researcher for advisory reference group members compared to researcher.</i>
<b>Documentary Evidence</b>  Miller and Alvarado 2005 Prior 2003 Robson 2002	<i>Provides additional material</i>  <i>Unobtrusive and non-reactive</i>  <i>Provide valuable cross-validation of other measures</i>	<i>Not all evidence may be publicly available and therefore only a partial or unrepresentative data may be secured.</i>

operational and ethical challenges that arose will be shared in the enacted story

#### **4.7.1 The espoused design**

Initially data collection using the research instruments was to be carried out in four sequential sub-stages. Figure 4.1 below is a summary of the planned stages and the desired outcomes.

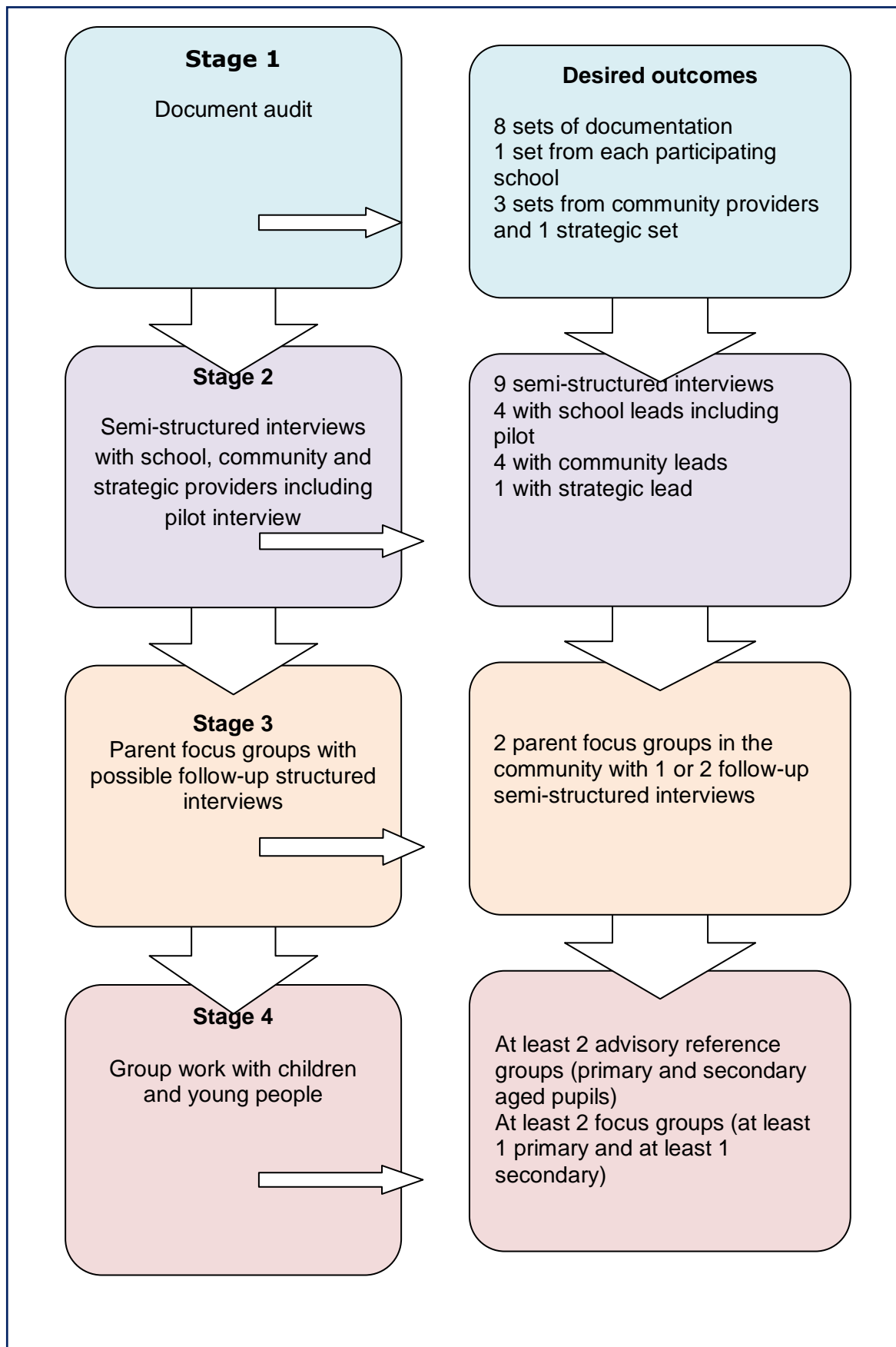
For each stage, a summary of the process of recruitment of participants and development of the research method is described.

##### **4.7.1.1      Stage 1: Document Audit**

###### *Data Sources*

As indicated in Figure 4.1 the overall aim was to secure by purposive sampling a maximum of 8 sets of documentation. The documents sought were primarily policy information or action plans that were linked to the NSHP initiatives in the cluster. Four sets of documentation would be from the participating schools and the remaining sets from the community (3) and strategic providers (1).

**Figure 4.1 Overview of planned fieldwork data collection stages**



These documents were requested in the written and oral communication to the headteachers and/or the Healthy Schools coordinators for the schools, and to community partners, when seeking their participation in the research and interviews when appropriate. The plan was to secure as much of the documentation before the semi-structured interviews as feasible, and if that was not possible to seek to secure documentation at the time of the interviews.

### *Research method*

A document summary form (DSF) (Appendix 4.3) was devised based on a template by Miles and Huberman (1994) to record the following data:

- the name and description of the document;
- the events or contacts, if any, with which the document was associated;  
the significance or importance of the document in relation to the  
purposes of the research; and
- a summary of the contents

The summary document was used to record reflective as well as factual data.

#### 4.7.1.2 Stage 2: Semi-structured interviews with school, community and strategic providers, including pilot interview

##### *Participants* ◀

Within the cluster the participants approached for interviews were the designated Healthy Schools/Setting Coordinators (HSCs)<sup>7</sup> of the four schools in the cluster who agreed to participate in the study. The children's centre/nursery school was labelled 'CC1'; the two primary schools were labelled 'PS1' and 'PS2' and the secondary school 'SS1'. The first interview conducted was construed as a 'pilot interview' and this took place with the Healthy Setting Coordinator in CC1

I had defined 'community' providers as those who were named in the cluster action plan as supporting and/or delivering initiatives linked to the obesity targets in the cluster action plan. Four community leads were approached for interviews. Three of these potential participants worked permanently in the cluster; the Extended Services Cluster coordinator, the manager of the local community sports centre and the cluster's P.E. Coordinator. The fourth potential participant, through a seconded post was working for two strategic (exosystemic) services, a local NHS primary care trust and the local authority Health Education Service as an advisory 'Healthy Schools' nurse. This fourth participant was given community 'status' rather than 'strategic' for the purposes of this research study because at the time of the fieldwork collection she was

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<sup>7</sup> The Children Centre/Nursery School was participating in a local authority Early Years Healthy School Setting initiative based on the NHSP,, hence Healthy Setting Coordinator



doing specific work in the 'Westfield' cluster linked to its action plan. However there was a further consideration that, in securing the involvement of this participant, I would be able to gain some additional strategic perspectives alongside community data.

As a result of this participant's dual community/strategic role there was only one other strategic participant who was sought as a source of information from a city-wide strategic perspective: the Anti-Bullying Coordinator for the local authority. As anti-bullying is a key aspect of the emotional well being thread in the Healthy School Programme, I considered this participant an appropriate informant.

Participants were contacted by phone and email to negotiate a date and venue for the interview. Information was sent by post or email prior to the interviews. This included an information sheet, consent form (Appendix 4.4) and an overview of the questions (see Appendix 4.5 for examples).

### *Research method*

The research questions sought to explore the differential and shared perspectives on the role of Healthy Schools and the childhood obesity agenda. Despite the flexibility offered by the semi-structured interview approach it was clear that a "one size fit all" schedule would not be appropriate for all the interviews. I initially envisaged three types of schedule to reflect the range of providers in the cluster: one for schools, one for the community providers and a third for the strategic participant. As outlined below, all the schedules would

have common questions alongside specific probes related to the system under scrutiny.

Although my primary intent was to explore and listen, there was initially a desire to gain some quantitative data such as attitudinal ratings; for example perceptions about the level of influence afforded to childhood obesity in driving their NHSP initiatives, and the importance of weight status as a factor in bullying. However this positivist drive diminished as the study progressed, and the interview schedules in design and/or delivery, placed less emphasis on collecting quantitative data.

Although rooted in ethnographic research designs, Spradley's (1979) guidance on the formulation of research questions was useful in considering whether the questions created would ensure the collection of rich and valid data. The different question types are:

- descriptive –seeking biographical information, life histories, and anecdotes;
- structural – aiming to clarify how the interviewee organises his or her knowledge; the frameworks they use to make sense of the world;
- contrast – making comparisons between events and experiences; and
- evaluative – exploring interviewees' feelings towards someone or something

Table 4.4 provides a summary of the interview agendas informed by the research questions and formulation types described by Spradley (1979).

#### 4.7.1.3      Stage 3: Parent focus groups with possible follow-up semi-structured interviews

##### *Participants*

For this stage, the plan was to identify and use existing parental fora within the cluster to recruit participants to be involved in parent/carer focus groups. The criteria used to select appropriate fora that could be approached involved the range of ages of children, size of group, and regularity of meetings. The aim was to carry out a minimum of two focus groups sessions each involving 6-10 participants. An open recruitment approach was to be used through flyers and the provision of information sheets and consent forms distributed by staff working with the fora identified (see Appendix 4.6). There was no direct targeting of parents whose child's weight status may be a perceived cause of concern. However I did see the focus groups as a vehicle to invite the attending focus group participants through a confidential demographic questionnaire to participate in a further subsequent semi-structured interview to share any concerns about their child weight status, where this was relevant. The aim was to secure at least one interview participant from each of the two focus groups. This aspect allowed parents to self select on the basis of their judgements about their child's weight status and their concerns, rather than my questionnaire asking for specific data on the child's weight status.

**Table 4.4 Shared and individual agendas for the semi-structured interviews**

<b>Research Questions</b>	<b>Descriptive</b>	<b>Structural</b>	<b>Contrast</b>	<b>Evaluative</b>
1. What are the National Healthy School Programme (NHSP) initiatives promoted by partners, particularly schools, within an Extended Provision Cluster with regard to the prevention and management of childhood obesity?	<ul style="list-style-type: none"> <li>• Role and responsibilities of interviewee and functions of service</li> <li>• Internal and external partners involved</li> <li>• HSP framework</li> </ul>	<ul style="list-style-type: none"> <li>• Model of provision</li> </ul>	<ul style="list-style-type: none"> <li>• Past, current and future changes on policy and practice</li> </ul>	<ul style="list-style-type: none"> <li>• Importance of obesity (including targets) driving HSP agendas</li> <li>• Model of provision</li> </ul>
2. Do the shared and differential perspectives on policy and practice indicate how such initiatives serve to address and prevent potential negative psychosocial outcomes associated with childhood obesity?	<ul style="list-style-type: none"> <li>• The level of integration of HSP themes</li> <li>• Consultation with partners</li> </ul>		<ul style="list-style-type: none"> <li>• Bullying</li> <li>• Reducing the risk of 'unintended harm'</li> </ul>	<ul style="list-style-type: none"> <li>• Reducing the risk of 'unintended harm'</li> </ul>

### *Research method*

I had construed parents/carers as partners and stakeholders; however their positioning in this research was more as 'service users' of the provision being delivered and less as service providers. Essentially with regard to themes, parents/carers were being asked what they knew about 'Healthy Schools' and what they thought about the nature of the provision being delivered by the schools in the cluster through the Healthy Schools/Settings Programmes. Parents/carers were also asked about their concerns and ideas for improvement. In order to explore further their perceptions of psychosocial correlates of obesity, I sought to elicit their perceptions of the role of weight status as a factor in bullying. The schedule including the demographic questionnaire in Appendix 4.7 is in fact a second and final schedule. As discussed further below in the enacted design section, the rescheduling of the original planned time of the focus group meeting led to revisions of the original schedule and the flyer (See Appendix 4.8).

As noted above, I had envisaged the agendas for individual semi-structured interviews would be the same as for the focus groups. The process would just allow more descriptive probing to encourage the sharing of personal stories, in particular parents'/carers' perceptions of any positive and negative impact of the NHSP on their child. However as described in the enacted section below, I did not formulate an individual interview schedule, as these proposed individual semi-structured interviews did not take place.

#### 4.7.1.4 Group work with children and young people.

This stage was divided into two components. The first was the setting up of children and young people advisory reference groups to inform the second component, the proposed focused group work with children and young people in the cluster. Both groups were to be identified within the participating schools. The headteachers of schools were approached formally and informally through my EP visits, with a written overview of the proposed group work components (Appendix 4.9).

The written overview explained the purposes of the advisory reference and focus groups. The overview also outlined the required arrangements (e.g. responsibilities of the school and researcher, the number and length of sessions with groups) and the required actions before contact with the groups.

##### *4.7.1.4.1 Advisory Reference Groups*

###### *Participants*

Advisory reference groups of children and young people were to be established from existing children and young people's fora in the cluster, in the form of school councils. School councils are defined as democratically elected groups of pupils who represent their peers and enable pupils to become partners in their own education, making a positive contribution to the school environment and ethos (School Council UK Website, 2009). Therefore the council groups were considered for this study as appropriately representative to seek the views

of pupils in the participating schools on the design and conduct of the proposed research with children and young people. The initial plan was to establish advisory reference groups within each participating school. If this proved over-ambitious, the minimum I would accept would be one primary and one secondary aged group.

The primary purposes of the advisory reference groups were to seek pupils' views about the planned research and their contribution to the development of the format of the planned focus groups with children and young people. The groups would also be used to pilot some of the key activities planned for the focus groups. It was planned that the advisory reference groups would involve 4-6 participants and meet at least once before the focus groups, with the invitation given to meet again to share and discuss the findings from and plan for the dissemination of the research

In all the participating schools the Headteacher signposted the lead staff member for liaison, who was the person responsible for the coordination of the school council activities in the school. Liaison meetings were arranged in each school. I had envisaged the lead staff member would have a key role in the dissemination of the information sheets and consent forms to the parents and children for the primary and secondary groups (Appendices 4.11-4.13) responsibility for the collection of the signed consent forms, identifying a meeting space in the school, and carrying out the necessary liaison with staff for the children and young people to be able to attend the group at the specified time.

### *Research Method*

The agenda for the meetings of the advisory reference groups had four main components alongside the preliminaries of welcomes, group rules and the conclusions to the meeting. These were:

1. Advisory reference group members sharing their knowledge about 'research' and the role of children and young people in research
2. Researcher giving information about the role of the advisory reference group and the background and purposes of the research
3. Eliciting the views of advisory group members on the utility of the proposed research and how to engage children and young people in research, including the dissemination of findings.
4. Advisory reference group members piloting activities for the planned focus groups e.g. perceptions about the role of weight status as a factor in bullying.

The copies of the schedules in Appendix 4.13 and 4.14 are the final versions of the primary and secondary advisory reference group interview schedules that were used in the enacted design. For the primary group each question was presented in enlarged format on a flipchart. For the secondary group a PowerPoint presentation format was used.



#### *4.7.1.4.2. Children and young people's focus groups*

##### *Participants*

The participants for the focus groups were also to be recruited from already existing fora in the schools, or groups were to be created via negotiation with the schools. There would be at least one primary group and one secondary group. There was an acknowledgment that the opportunity, as with the advisory reference groups, was not given to younger children attending early years settings in the cluster to participate and engage. The reasons for this decision were largely pragmatic, driven by considerations of access and the number of groups that could be managed. However the decision-making did raise a personal professional challenge with regard to whether I construed very young children as competent and legitimate participants in the research process (Twycross et al., 2008). Although limited in number within published research, methodologies for listening to very young children are signposted (e.g. Clarke, 2005). I acknowledge therefore that it would have been feasible to include children from the children's centre nursery school in my study.

The focus groups would each involve 6-10 participants and run for at least one session. I asked for the minimum of one session primarily to ensure access with the view that if needed. Further sessions could be negotiated if required. I envisaged that consultation with the advisory reference group would inform the age range and gender composition of the focus groups. As with the advisory reference groups, the plan was to negotiate with the lead member of staff

involved to secure parental and child/young person consent (Appendices 4.16-4.18) and arrange the use of a meeting space.

### *Research Method*

The focus group schedules were similar in content to the planned parent focus groups. The children and young people were positioned as 'service users'. The questions, informed by the final research question (p85), were designed to:

- explore their knowledge and understanding of the Healthy School Programme;
- ascertain their preferences and dislikes with regard to the provision in place;
- seek their views as to whether "unintended harm" arose/might occur through health promotion activities in their schools;
- explore perceptions about the role of weight status as a comparative factor in bullying through a rating activity; and
- elicit ideas for improvements.

The processes were differentiated between the primary and secondary groups to facilitate engagement in light of their age and anticipated age-related differences in understanding: simpler language was used in the younger age group schedule. The primary group also had more interactive activities for the children to demonstrate their knowledge and understanding of the NHSP for example the use of a mind mapping exercise to explore their views and knowledge about 'Healthy Schools'. My reflections on the effectiveness of how

questions were displayed in the advisory reference group meetings via flipcharts or PowerPoint led to my creation of presentation booklets for each focus group as a source of individual reference for each question throughout the meeting. Again the copies of the schedules in Appendices 4.19 and 4.20 are the final versions of the focus group schedules used in the enacted design.

All the interviews and group meetings were to be recorded and later subject to transcription with the use of a digital audio recorder. This was indicated to all the participants in the information sheets and consent forms.

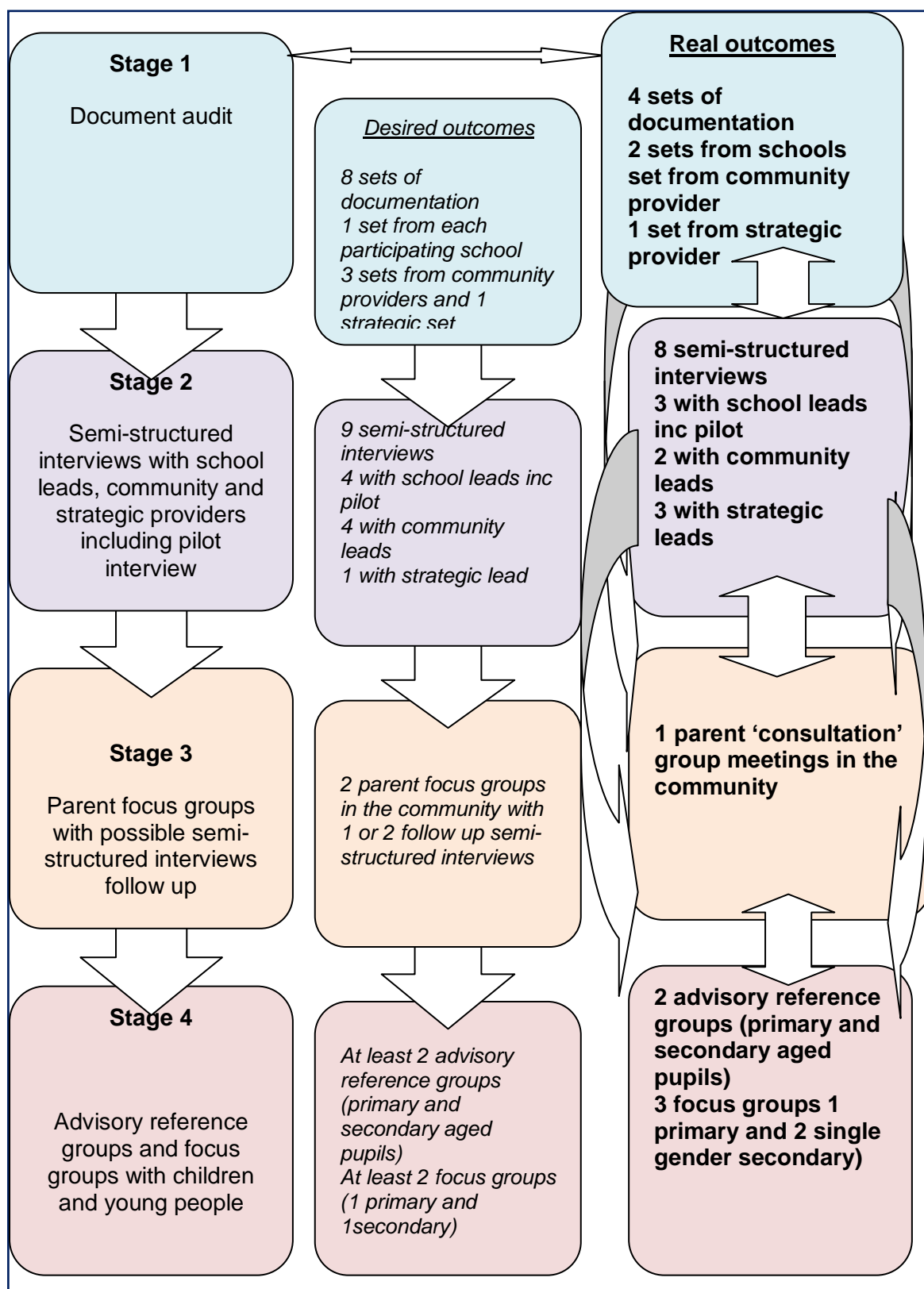
With all the four stages of the fieldwork planned, my interaction with the targeted participants could begin. I had envisaged that this 'real world' research would result in some changes to the design. However in practice this theory of the nature of the 'real world' research was challenged more than I expected, as shown by the outcomes of the enacted design.

#### **4.7.2 The enacted design**

The key purpose of this section is to summarise changes to the planned design and to highlight main reflection points, in particular the operational and ethical challenges that will be revisited in the Discussion chapters (Chapters 7 and 8).

Figure 4.2 overleaf presents the enacted design and outcomes. This figure also attempts not only to highlight the changed outcomes but also to illustrate how

**Figure 4.2 Enacted fieldwork data collection stages**



the enacted design resulted in the fieldwork stages becoming more integrated. The planning and delivery of activities at times occurred in parallel.

A common theme in the operational challenges was the need repeatedly to reschedule times for interviews and focus groups. This was often the result of events in the schools taking priority, including participant ill health, poor turnout and/or participant withdrawal from the study. On the positive side, sometimes these delays provided opportunities to reflect on and consider changes to the design. The less positive outcome was reducing the scope for repeated contact with participants and the difficulty in sustaining momentum for the study. Below, as with the espoused design, the summary of the changes in recruitment of participants and development of research methods are described.

#### 4.7.2.1 Stage 1: Document Audit

##### *Data Sources*

Four sets of documentation were secured rather than the planned eight. The number and relevance of the secured documents was affected by my dependence on the participants as intermediaries and the time of access. The documents made available did represent in part the different systemic levels I wanted to explore; two sets were obtained from schools (CC1 and SS1), one set from a community participant (ESCC) and the last set from the 'strategic' participant (ABC). With the exception of the documentation from the secondary school, which was finally secured 6 months after the interview, all the

documentation was made available prior to or at the time of the interviews. Poor return from the other sources was attributed to participant sick leave and withdrawal, alongside documentation not provided by the participants despite further requests following the interviews. The loss of two community participants as described below also affected my ability to obtain documentation that could potentially give more information about provision in the community. The original and additional strategic participants, who participated, did signpost further documentation that would be useful to add to the literature review rather than act as a document source for the study. For example documentation that was available on the 'Healthy Schools' website.

Even with the documentation secured there was an acceptance that the participants had determined what could be made available and that this could impact on the quality of information of relevance to the study. Therefore I saw these secured sources as only part of the story with regard to the role and content of documentation linked to childhood obesity agendas in the cluster.

This poor return and contingent curtailment of my endeavours led me to reflect on the social processes at play that affected the exchange of these documents (Miller & Alvarado 2005). I reflected on my contribution and queried the extent and impact of my proactivity and communicative effectiveness in securing what I wanted from participants, particularly the school and community providers. A recurring theme was whether my role as an EP in the cluster had made me too circumspect in making demands, for fear of abusing my existing role relationship and exerting coercive pressures in an ethically indefensible way; as

a result, I erred on the side of caution. I feel that this ambivalence and circumspection was a recurrent theme through all stages of the fieldwork. Initially I had considered my role as “insider” to be an advantage in handling the expected research challenge of managing the tension between getting the research done whilst respecting the 'voluntariness' of participation from others. However my experiences as I conducted the research made me question whether it was equally a disadvantage to the process.

### *Research Methods*

No changes were made to the framework of the document summary forms.

#### 4.7.2.2      Stage 2: Semi-structured interviews with providers

### *Participants*

As indicated above, originally nine ‘provider’ participants had been purposively selected for the semi-structured interviews. All had orally agreed to participate in the study through initial overtures at the start of the fieldwork collection. From that number six were interviewed along with two ‘additional’ participants making a total of eight respondents.

Three of the four healthy school/setting coordinators from the participating schools were interviewed; CC1, PS1 and SS1. Initially as a result of ill health and then subsequent reported work commitments the healthy school coordinator from PS2 passively withdrew from the study. I have used the

‘passive’ descriptor, as the participant never communicated to me the decision not to take part; rather I interpreted the signals given over time as an indication that the participant no longer wanted to take part. I also had to manage the ethical tension of dual working with this participant, as a result our joint involvement in an additional EP consultation activity in the school. It was important to demark these roles, which led to my decision only to solicit contact and discuss the research with this participant during school visits not linked to the consultation activity.

Two of the four targeted community providers were interviewed: the extended services cluster coordinator (ESCC) and the Community Sports Centre Manager (SCM). The Cluster PE Coordinator took up another post before arrangements for an interview could be set in place. The advisory healthy school nurse also ‘passively withdrew’ following a series of repeated rescheduling and cancellations. In hindsight I should have accepted this passive withdrawal much sooner however my desire to include a participant who could provide some insight into the role of the primary care trust as well the local authority within the cluster was a key factor for delaying my response to the signals that I later recognised had been given.

My existing knowledge of the cluster led me to seek out strategic ‘alterative’ providers with regard to PE and Health Education, as I knew there were no comparable community alternatives. I was able to secure interviews with a PE consultant (PEC) working within the LA advisory service and the local authority’s lead advisor from the Health Education Service (HSCHEs), which



serves as the lead strategic service supporting the implementation of the Healthy Schools Programme in the City. Although value was gained from securing further perspectives at the exosystemic level, I was concerned that mesosystemic and microsystemic perspectives had been weakened by the reduction in 'community' participants. All the school lead interviews took place in the school settings. The Sports Centre manager and the Anti- Bullying coordinator were interviewed at their place of work. The remaining interviews took place in a meeting room at my own work setting.

### *Research Methods*

The inclusion of the two alternative strategic participants meant that additional semi-structured interviews had to be designed. As with the Anti-Bullying Coordinator, the interview schedules also served as an overview that was sent to the strategic participants prior to the interviews (see 4.20 for extracts from overviews).

#### 4.7.2.3      Stage 3: Parent/Carer focus groups and follow up semi-structured interviews

### *Participants*

This was the part of the design that was subject to the most revision as the planned focus groups with parents did not go ahead despite my own active endeavours and recourse to a number of strategies informed by advice from community-based professionals.

At the onset, the parent group that met at CC1 had been identified as an appropriate forum from which to recruit participants, since the group met regularly and many of the parents reportedly had older children attending schools in the cluster. I liaised with the Healthy Setting Coordinator at the centre with regard to publicity, the dissemination of flyers, information sheets, consents forms and the use of the parent meeting room as a venue. The low turnout on the original date led to the meeting being cancelled due to tangible signs of lack of expressed interest by this group. A rescheduled date was agreed and I used the interim period to revise the content of the session, in particular with regard to the number of questions that were to be asked. However as a result of a request from the Children's Centre/Nursery School the rescheduled focus group meeting was also cancelled. The reasons given were staff sickness and the plethora of initiatives also taking place at the Centre at the same time.

Subsequent discussions with the Healthy Setting Coordinator led to my agreement to look at alternative ways to engage parents. There was concern that the formal nature of being part of a focus group may have contributed to the reluctance of parents to participate. As a result of these ongoing discussions, I was afforded the opportunity to attend the last session of an existing local community intervention with parents to share my research and elicit parent/carer views in a 20-minute time slot. I found five parents on my arrival at the group meeting. A key ethical concern was not to raise the research topic in the general conversation prior to my formal introduction, and the point at which I secured their oral agreement to participate and give written consent for my use

of views shared in the meeting (Appendix 4.21). Parents were invited at the end of the session, orally and by the written information sheet (Appendix 4.22), to make contact if they were interested in sharing their views in an individual interview. No follow up contact was received.

Further unsuccessful attempts were made to identify other parent fora in the community. For example through discussion with the cluster coordinator another community group was identified. The cluster coordinator had facilitated my attendance at the next meeting to talk about my study. However this meeting was also cancelled. I kept in contact with the cluster coordinator to gain a rescheduled date; however there came a point in the study time frame when waiting for this community group meeting to take place was no longer feasible. This meant that despite significant efforts in trying to secure parental involvement, this proved an elusive goal.

### *Research Methods*

A less formal and structured approach was adopted to elicit parental views within the restricted time slot. The information sheet devised for parents also served as a script to prompt discussion. Again the themes within this script were similar to the original focus group schedule. The lack of expression of interest to participate in individual follow up interviews preventing my developing the proposed interview schedule.

#### 4.7.2.4 Stage 4: Group work with children and young people

The group work with children and young people took place in PS1 and SS1. PS2 withdrew from taking part. A telephone conversation with the Headteacher of PS2 took place to discuss this and I was able to secure permission from the Head to use my notes from our discussion as data in the study. A key focus of this research was about how providers were minimising “unintended” harm by their activities. The withdrawal was based on the Headteacher’s concern that the research activity itself would draw negative focus to children who were overweight and obese in the school. Although the group work did not go ahead, the opportunity to provide a defence based on my ethical considerations was a useful learning experience.

##### 4.7.2.4.1 Advisory Reference Groups

###### *Participants*

For the PS1 group, ten children attended the session with an age range from Y1 (age 5-6) to Y6 (age 10-11). The school council group of SS1 was smaller in number, comprising four participants from year groups Y7–Y10. The four young people were the leads of their school council year groups. School staff felt that it was not appropriate for Y11 representation due to exam preparations in the school. The recruitment of participants in PS1 and SS1 was carried out in different ways. The liaison leads did support the recruitment process as planned; however I was in a position to take advantage of an invitation to attend SS1 school council meeting to give a brief overview of the study, invite participation and give out the information sheets and consent forms. This

preliminary meeting was not possible with the PS1 school council as the next meeting was the most suitable date to engage with pupils as an advisory reference group.

Reliance on staff leads to support the recruitment and organisations of groups did lead to operational and ethical challenges. For example on the day of the PS1 group, I found on arrival that although the staff lead had disseminated and collected the parental consent forms, the children's consent forms had not been done. Therefore I had to secure the participants' consent at the start of the session. I sensed that, with the pupils, I had a captive audience and the tangible power dynamics greatly reduced the probability of dissent or withdrawal when the information sheet and consent forms were discussed. The need to complete these forms also had the impact of reducing the time available for the group meeting to pursue the planned focus group activities. This meant that I only had time to prioritise one pilot activity and I chose the bullying activity as outlined in Appendix 4.13

This prioritisation also happened with the secondary group with regard to the real time available once the meeting started. In the secondary school, in order to secure a full hour, part of the lunch hour had to be used and on the days when focus groups were conducted, arrangements to secure lunch before the meeting affected the start time.

Another ethical issue was the nature of informed consent with parents. The deputy head teacher of PS1, who sat in on the group, made the comment that

oral summaries of the information sheet and consent form had to be given to some parents due to poor literacy and English communication skills. I had no control as to whether these oral summaries had indeed ensured fully informed consent. Again this raised questions of securing the right balance of ensuring all ethical requirements are addressed in written information when intermediaries, (including children) are used to convey that information.

### *Research Methods*

There were no significant changes to the schedules used in the primary and secondary advisory reference group other than certain slides or sheets acting more as prompts for myself rather than a direct reading source for participants. Following these sessions I created “certificates of appreciation” (Appendix 4.23) for each participant in the group for the lead member of staff to give to the participants along with my thanks again for their involvement.

#### 4.7.2.4.1 Children and Young People’s Focus Groups

### *Participants*

The outcomes of the sessions with the advisory reference groups generated reflection on my part which informed the work with the focus groups. This will be discussed further in the second discussion chapter on methodological considerations (Chapter 8).

The primary advisory reference group had suggested it was more appropriate to work with older pupils in the school for the purposes of the study. I asked the

lead member of staff to select a mixed gender group of six-eight Y5 and Y6 pupils and arrange for the consent forms to be completed. On the day of the focus group meeting, the school lead reported that only four consent forms had been returned from targeted pupils. The school lead suggested that she could make available two participants who had taken part in the advisory reference group as consent forms had been signed. This was another ethical challenge as technically the parents and children involved had agreed to a specific activity rather than to a general invitation to take part in the research study. I made the uncomfortable decision to agree to the suggestion, on the justification that the themes that were to be explored in the focus group had been raised in the advisory reference group. Therefore the primary focus group was made up of six participants.

The secondary advisory reference group had made the key recommendation for single sex groups. The group had also recommended open recruitment rather than targeted selection by staff. However after a meeting with the lead member of staff it was agreed to recruit from the year council groups, as they formed a readily available representative cohort of young people in the school, and there was also the advantage of the set timing of these meetings that could accommodate carrying out alternative activities such as the focus group meetings. Consequently I visited the year group council meetings for Years 7, 8, 9 and 10. These fora consisted of a male and female representative of each tutor group in each year. I invited participation and handed out the parent and young people information sheets and consent forms. In response a male (4 participants) and a female group (4 participants) were run. Three participants

(one female and two males) had also taken part in the advisory reference group. Both group meetings were rescheduled due to school events. This may have been a factor in the non attendance of two additional participants, one boy and one girl who had returned consent forms but did not take part. There was also the additional problem that ready access to the lead member of staff in the secondary school to resolve the problems with delays was not always possible, due to their own busy schedule.

As with the primary group, a recurring theme was the impact of time pressures and in hindsight I felt I should not have requested one meeting with each group as a minimum. It would have been better to negotiate a higher number of meetings at the start rather than adopt “a wait and see” approach. I also felt the rescheduling of the meetings had an impact in reducing further windows of opportunity to hold additional group meetings with the participants. The extended research time frame overlapped with other planned events going on in the school including end of year exams. As a result when overtures were made to SS1 about additional meetings the feedback was that the school was not able to accommodate this request.

### *Research Methods*

There was a significant revision to the proposed schedule. My interactions with child participants prior to these focus groups led me to recognise that I needed to acknowledge openly my status as an obese person and reduce risks that it may act as a potential barrier in group discussion. I therefore incorporated a ‘warm up ’ activity where terms related to weight status were explored and



where I could signal openly that my roles as an adult, psychologist and a researcher overrode personal sensibilities around the use of agreed terms and discussions about obesity. I did note in my reflections that I had not considered the need to do this with adult participants, and I wondered if this was a significant omission in the research process.

As with the advisory reference groups, certificates of appreciation were created and delivered to the schools following the focus group sessions.

To summarise, the original design was substantively revised in content and time to accommodate the many logistical difficulties encountered in the implementation of the study. Table 4.5 below provides an overview of the numbers and participants in the study. . From my own perspective, I was disappointed to have secured fifty percent of adult participants and eighty eight percent of children and young people with regard to the originally planned number I would have liked to have been involved in the study.

With the fieldwork collection stages coming to an end I now turned my attention the final stages of the research design. As stated in the overview above, I intend to report on the next stage (Stage 5), the planned methods of analysis, in the following chapter. It seems appropriate here to end this section by reporting on the final the stage of the research design with regard to dissemination to stakeholders and participants. In total the study involved 12 adult participants and 35 children and young people. From my own perspective, I was disappointed to have secured fifty percent of adult participants and eighty eight

percent of children and young people with regard to the originally planned number I would have liked to have been involved in the study.

Table 4.5 Roles and numbers of participants in the study.					
Number of participants		SSIs	ARGs	FOCUS GROUPS	Total no
Adults	School Leads	3			3
	Community Leads	1			1
	Strategic Leads	3			3
	Parent/ Carer/s	0		5	5
Total Number of Adults					12
Children and Young People	Primary aged		10	6	14
	Secondary aged		4	8	9
Total Number of children and young people					23
			Total no of participants		35
SSIs – Semi structured interviews ARGs – Advisory reference groups					

#### **4.8 Stage 6: Dissemination to stakeholders and participants**

As part of the fieldwork discussion took place with the participants with regard to the dissemination of findings. All expressed interest in hearing about the findings of the study through a range of media such as presentations and written feedback. The children and young people also expressed an interest in playing a role in disseminating the findings to their peers. It is likely that as a result of the extended time frame I may experience some difficulties in making contact with all of the participants, for example pupils and staff who may have left the schools.

## **CHAPTER FIVE: METHDOLOGY PART THREE CHOSEN METHODS OF ANLAYSIS**

**“..it is important to recognise that qualitative data analysis processes are not entirely distinguishable from the actual data. The theoretical lens from which the researcher approaches the phenomenon, the strategies that the researcher uses to collect or construct data, and the understandings that the researcher has about what might count as relevant or important data in answering the research question are all analytic processes that influence the data.”**

**[Thorne, 2000 p68]**

### **5.1 The role of the literature review**

Willig (2001) states researchers should never collect data without having decided how to analyse them. In determining my own choice of method, analysis methods commonly undertaken within the UK research studies on childhood obesity were considered. The studies by Willis and colleagues (2006) and Holt and colleagues (2005) makes reference to the use of QSR NUD\*IST, the qualitative data-indexing package. This package assists the format of the analysis rather than determining the nature of the analysis (Robson, 2002). I have assumed that Holt and colleagues' (2005) reference to Strauss and Corbin (1998) implies that their quoted meta-analysis used grounded theory methodology. Murtagh and colleagues (2006) describe the use of an analysis technique by Ritchie and Spencer (1994) that entails stages of familiarisation, theme identification, indexing, charting, mapping and interpretation.

It was clear that, at a basic level, chosen methods of analysis would entail looking at the content of data in text form. In research, 'content analysis' is a generic name for a variety of means of textual analyses that involve comparing, contrasting and categorising a corpus of data by both numeric and interpretive means (Gerbic and Stacey, 2005).

Thematic analysis is the term used to describe content analysis approaches that pay greater attention to the qualitative aspects of the material analysed (Joffe and Yardley; 2003, Boyatzis, 1998). Thematic analysis is a method for identifying, analysing, and reporting on thematic patterns within a data corpus (Woodhouse, 2006).

I saw thematic analysis as a suitable approach for analysis with regard to the exploratory aims of the study as opposed to alternative structured approaches such as Foucauldian discourse analysis (Henriques et al., 1984), or grounded theory (Glaser and Strauss, 1967), as my purposes were not about neither the role of language in the construction of social reality nor theory generation.

Two thematic analysis frameworks of interest emerged from the review of literature that reflected different positions on how inductive or deductive the thematic process should be from the onset. The 'template analysis' approach indicates as an option a clear set of 'a priori' codes *and* themes before engaging with data, with these codes/themes then revised and finalised over time (King, 1998; 2004). By contrast the framework of Braun and Clarke (2006) follows the

more traditional standing that although thematic analysis may involve the formulation of initial thoughts and codes, themes *emerge* and this very emergence is important to the description of the phenomenon (Daly et al., 1997).

## **5.2. A hybrid thematic analysis approach**

As this was an exploratory study, I judged the framework of Braun and Clarke best suited to the objectives of my study. I summarised the Braun and Clarke article into a guidance document to structure my approach to the analysis, and this is summarised in Table 5.1.

In reviewing this guidance a key question was whether all my sources of data would be subject to equal rigour within the analysis undertaken. To summarise the sources of data were:

1. semi-structured interviews;
2. advisory and focus groups meetings;
3. additional contact/fieldwork notes; and
4. documents including document summary forms.

It could be argued that all the sources of data are 'documents' as they are represented in textual forms. However within this study, two levels of distinction were made. First of all a distinction was made between the first three sources and

**Table 5.1: Guidance document based on the summary of phases in Braun and Clarke's (2006) thematic analysis model**

**PRE PHASES**

- You need to define your data: as Corpus, Set Item
- Phase 2-4 should be done for each data item in turn and then repeat phase 3 and 4 as a collated set of items

**PHASE 1: Familiarizing yourself with your data:** *Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.*

- What are my initial analytic interests or thoughts?
- What meanings and patterns emerge with the initial reading of the data before coding?

**PHASE 2: Generating initial codes:** *Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code*

- Initial codes for the data?
- List all codes used

**PHASE 3: Searching for themes:** *Collating codes into potential themes, gathering all data relevant to each potential theme*

- What themes are generated by the codes?
- Do the initial themes become sub themes of larger themes?
- Make a visual representation of the links between codes and themes

**PHASE 4: Reviewing themes:** *Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis*

- What themes are generated by the codes?
- Do the initial themes become sub themes of larger themes?
- Make a visual representation of the links between codes and themes

**PHASE 5: Defining and naming themes:** *Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.*

- What are the final themes for you to use in your analysis. Summarise their "essence".
- What is the story of your themes? Do the stories give answers to your research questions – do they relate?

**PHASE 6: Producing the report:** *The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.*

- What are the final themes for you to use in your analysis. Summarise their "essence".
- What is the story of your themes? Do the stories give answers to your research questions – do they relate?

the fourth in two key ways. The first was the way the sources were generated (Miller and Alvarado 2005). The interviews and focus group meetings were transcribed and fieldwork notes were produced under my control, whereas the documents secured from participants in the setting were not generated by myself and existed before I sought to use them as data. Secondly, the use of 'documents' was always positioned as a secondary source of data. I positioned the documents as a 'resource' rather than as active agents and a 'topic' in the network of action as with the other data sets (Prior, 2008).

The second distinction occurred between the sources of data in the 'generated set'. The transcriptions from the semi-structured interviews and focus group meetings were reconstructions of the 'live action' that took place between the participants and myself. The contact information/fieldwork notes were, in essence, my interpretation and reflections of what had happened, rather than a live record.

Consequently the analyses for these data sources were approached in slightly different ways and the analysis process became a hybrid version of the Braun and Clarke (2006) model and King's (1998; 2004) template analysis approach. I saw the template analysis approach giving me more flexibility to determine a level of analysis that was appropriate for each secondary source, whether documents, contact summary forms, fieldwork notes or supervision records without going through all steps of the phases of the Braun and Clarke model. Alternative hybrid approaches within thematic analysis can be found in the literature (e.g. Fereday and Muir-Cochrane, 2006).

The data from the semi-structured interviews and the focus group meetings were positioned as primary sources of data and subjected to the Braun and Clarke (2006) model summarised in Table 5.1. The themes generated by these sources at Phase 3 would be used to provide an initial 'a priori' template to engage with the data from the secondary sources using the template analysis approach. In King's original model, a template is generated for each type of source. However I felt the categories that emerged from the primary sources (interviews and focus groups) wide ranging and rich enough for the template of categories derived from these to be applied to all the secondary sources of data.

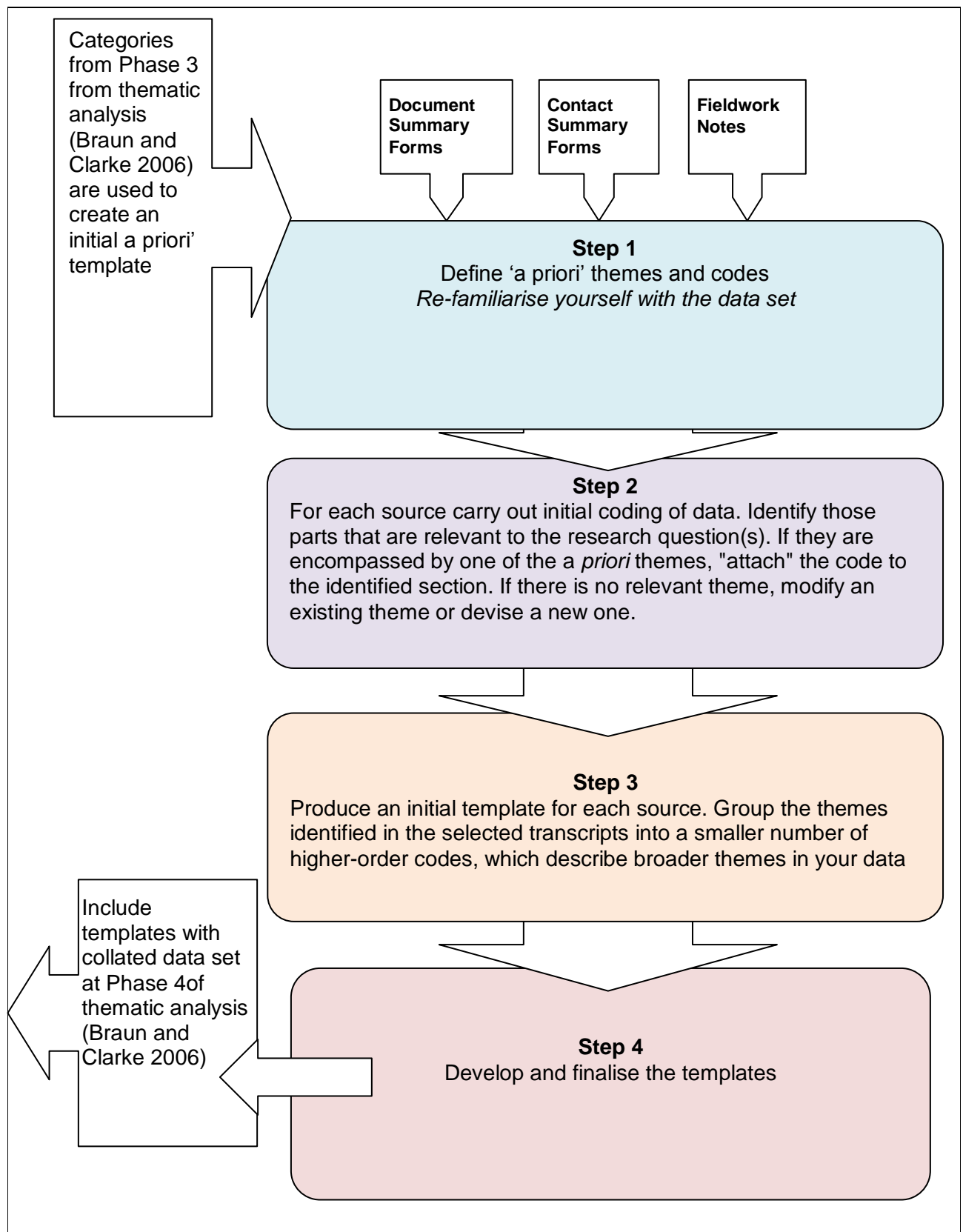
As indicated by Figure 5.1 this template analysis approach based on King's (1998; 2004) mode, I which involves four steps:

1. refamiliarisation with the data set and defining the use of the 'a priori' themes and codes;
2. coding of sources with the 'a priori' template that may lead to revised and new codes;
3. grouping codes into higher order codes which describe broad themes in the data; and
4. developing and finalising the templates of themes.

Once the secondary sources had been analysed through these template steps, the coded data and emerging themes could be collated alongside the coded



**Figure 5.1: A template analysis approach to apply to the secondary sources of data (based on King 2004; 1998).**



the analysis will provide more detail as to how this hybrid framework was primary sources of data for the completion of the analysis process using the remaining phases (4-6) of the Braun and Clarke model. The following chapter on the analysis of the data will provide more detail as to how this hybrid framework was operationsiled and what themes emerged from the ongoing interpretation and discussion.

### **5.3: Conclusion to the three methodology chapters**

I chose a pragmatic paradigm to provide flexibility to explore epistemological positions out of my comfort zone and have fluidity in the research design to accommodate the learning experiences that arose through the research activities. Initially, I expected the major challenges I would face to be the ghost of positivism; the holding onto emancipatory values; and my inexperience in planning and undertaking (to me) novel qualitative research methods in collecting and analysing data. However, day-to-day operational barriers such as maintaining participant involvement and dealing with delays were found to be as equally challenging than these paradigmatic concerns.

I achieved partial success in attaining the desired outcomes of the planned research design and had to accept that a range of factors contributed to the difficulties I experienced in obtaining data from all the respondent groups whose views I wished to canvas. I needed to consider the limits of my research design alongside its strengths to make a judgement about whether the methods chosen were fit for purpose. I also needed to consider my effectiveness as the key

research instrument, and the roles of participants in the process. These methodological considerations will be explored further and addressed in the second of two discussion chapters that now follow.

## **CHAPTER 6: ANALYSIS OF DATA**

**“Theme identification is one of the most fundamental tasks in qualitative research. It is also one of the most mysterious.”**

**[Ryan and Bernard 2003 p85]**

### **6.1 Introduction**

This chapter provides a more detailed focus on the analytical processes carried out on the data corpus collected during the fieldwork stage of the study. It will demonstrate how the chosen hybrid analysis framework that is primarily based on the Braun and Clarke (2006) thematic analysis model became operationalised. This chapter is the story of the first five phases of the model, including the incorporated template analysis steps (King, 1998; 2004) that took place within Phase Three. The following discussion chapter is in essence Phase Six, the last phase of the model, where the key themes that arose from the analysis are interlinked with the literature through discussion with reference to the original data from which themes were derived.

### **6.2. Clarification of terms**

Thematic analysis involves the use of codes and development of themes. Cresswell and Plano Clark (2007) describe coding as a process for grouping evidence and labelling ideas. Braun and Clarke (2006) adopt Boyatzis' (1998 p63) definition of a code, “the most basic segment or element of the raw data or

information that can be assessed in a meaningful way regarding the phenomenon". Boyatzis (1998 p4) defines a theme as a pattern found in the information that, at the minimum describes and organizes possible observations, or at the maximum, interprets aspects of the phenomenon'. Braun and Clarke (2006) see themes as broader units of analysis than codes, where the interpretive analysis of the data occurs.

I found this distinction between codes and themes at times artificial, as it could be argued that coding data even at a basic level is an interpretative act (Miles and Huberman, 1994). Boyatzis (1998 preface) himself appears to use the terms codes and themes interchangeably. He talks about "a good code may emerge from one of more original themes. Once it is developed as a code, it becomes the form of the original themes that the researcher uses throughout his or her inquiry". I adopted Miles and Huberman's (1994) perspective of considering themes as higher order codes to indicate higher forms of abstraction, which have developed as the result of the clustering of codes (Robson, 2002; Smith and Osborn, 2003).

The literature on thematic analysis also creates a distinction between deductive and inductive approaches (Braun and Clark 2006; Robson 2002; Boyatzis 1998; Miles and Huberman 1994). The former are linked to 'theory-driven' approaches where the data are approached with clear purposes in terms of 'a priori' theory or research questions. This could also involve the use of a pre-existing codebook that has been developed to code the data. In contrast data-

driven approaches facilitate the emergence of codes and themes. In fact Boyatzis (1998) considers the approaches to be on a continuum. All have the same end point, which is theory development. The difference is the starting point. As highlighted below, at times this divide between inductive and deductive approaches began to feel contrived as the coding took place.

### **6.3 Instruments of Analysis**

Robson (2002) cites Fetterman (1989) who states that the analysis is as much a test of the enquirer as it is a test of the data. My role as the researcher and analyst of the data positioned me again as another important research instrument in this study. My readings on thematic analysis led me to position myself as a novice whose prior experiences of qualitative analysis were rooted in the use of content analysis models.

Those experiences and reading of the literature on qualitative research highlighted a key aspect of my role as the analyst: that the analysis stage was no different from other aspects of the research activity with regard to the involvement of emotional value-laden and theoretical preconceptions, preferences and world views (Boyatzis 1998). Indeed Boyatzis' (1998) comments on the mood and style of the researcher (e.g. fatigue, sensory overload, frustration, confusion) affecting abilities did hold a resonance during the analysis journey. Table 6.1 shows Robson's (2002) list of the 'deficiencies

‘of the human as an analyst which I saw would be useful prompts during this analysis journey. As a lone analyst the risks could be exacerbated due to the lack of opportunity for co-conference with and moderation by other colleagues. I envisaged the importance of structured ‘time out’ from the analysis and the recursive nature of the analysis approach as described below as means to minimise these risks.

**Table 6.1: Robson (2002): List of the deficiencies of the human as an analyst**

1. *Data overload*
2. *First impressions* – future revision resisted
3. *Information availability* – information which is difficult to get hold of gets less attention than that which was easier to obtain
4. *Positive instances* – tendency to ignore conflicting hypotheses and emphasize info that confirms
5. *Internal consistency* – tendency to discount the novel and unusual
6. *Uneven reliability* – the fact that some sources are more reliable than others tend to be ignored
7. *Missing information* – Something for which information is incomplete tends to be devalued
8. *Revision of hypotheses* – there is a tendency to either to over or to under react to new information
9. *Fictional base* – the tendency to compare with a base or average when no base data is available
10. *Confidence in judgement* – Excessive confidence is rested in one’s judgement once it is made
11. *Co-occurrence* – Tends to be interpreted as strong evidence for correlation
12. *Inconsistency* – repeated evaluations of the same data tend to differ

NVivo 8 (QSR International 2009) was the choice of software to support the analysis process. I did experience the advantages of using software as summarised by Robson (2002) below in Table 6.2. Regarding the disadvantages, it was important to acknowledge potential attributions of error

may be misdirected at the software and not myself as the analyst. Willig (2001) warns that the computer can be no more than a tool in the service of the researcher; it has no creative abilities of its own. Bazeley (2007) also argues that computer software cannot make good work that is sloppy, nor compensate for limited interpretive capacity.

**Table 6.2: Summary of Robson's (2002) overview of advantages of computer software in analysis.**

Advantages

- It provides an organized single location storage system for all stored materials
- It gives quick and easy access to material
- It can handle large amounts of data very quickly
- It forces detailed consideration of all text in the database on a line by line (or similar) basis
- It helps the development of consistent coding themes

## 6.4 Analysis Framework

Braun and Clarke (2006), stress that thematic analysis is a *recursive* as opposed to linear process. Although represented in a linear structure previously (p161 and p164) and below, my experience and reflections entailed two distinct stages that involved recursive processes. The first stage incorporated Phases 1-3, including the template phase. All these steps incorporated the revisiting of previous phases. For example generating initial



codes (Phase 2) always entailed re-familiarisation with the data (Phase 1). Equally searching for themes (Phase 3) led to the generation of new codes (Phase 2) through my improved familiarization with the data (Phase 1).

The second recursive stage involved an interactive process between Phases 4 and 5. Clearly this second stage involved re-familiarization with the data and the search for themes. However I made a conscious decision not to move back into Phase 2 to ensure that coding for codes should cease and emphasis would be placed on clarifying and developing superordinate themes.

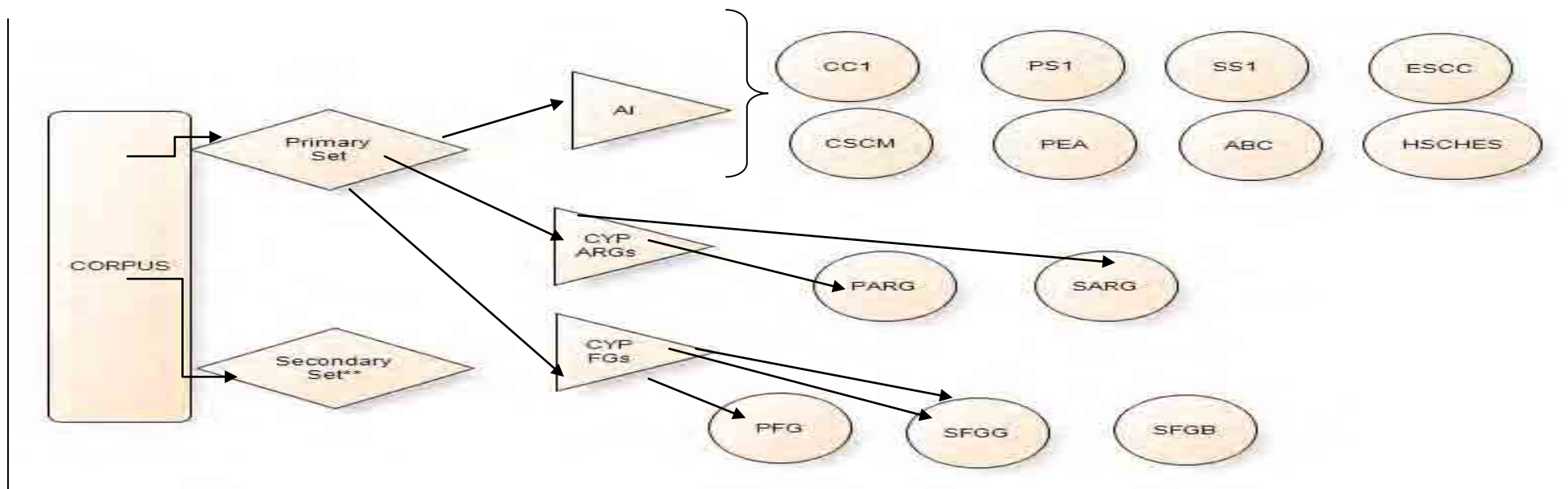
The previous methodology chapter on the chosen methods of analysis already indicated how the corpus of fieldwork data was categorised into two data sets – primary and secondary sources of data. The primary sources were dealt with first and subject to the first three phases of the Braun and Clarke model (2006), which are now described below.

#### **6.4.1 Familiarizing yourself with your data (Phase 1):** *Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.*

The primary data set entailed thirteen data items as illustrated in Figure 6.1; transcriptions of eight adult interviews, two children's advisory reference group meetings and three child focus groups meetings were read and reread.

Illustrative extracts from selected transcripts from the semi-structured

**Figure 6.1 Primary Sources of data subjected to phases 1 -3 of the Braun and Clarke's (2006) Model**



**KEY**

AI – Adult Interviews  
 CYP ARGs – Children and Young People  
 Advisory Reference Groups  
 CYPFGs – Children and Young People  
 Focus Groups

\*See Figure 6.3 p179, for information on the  
 secondary set

CC – Children Centre  
 PS1 – Primary School 1  
 SS1- Secondary School 1  
 ESCC- Extended Services Cluster Coordinator  
 CSCM- Community Sports Centre Manager  
 PEC- PE Consultant  
 ABC- Anti-Bullying Coordinator  
 HSCHEs- HSP Coordinator Health Education Service

PARG- Primary Reference Group  
 SARG- Secondary Reference Group  
 PFG- Primary Focus Group  
 SFGG- Secondary Focus Group Girls  
 SFGB- Secondary Focus Group Boys

interviews, the advisory reference groups and the children and young people's focus group meetings, can be found in Appendix 6.1, 6.2, and 6.3 respectively.

The primary purpose of the familiarization phase was to note down initial ideas. This phase also created opportunities to recheck the accuracy of transcriptions, which did not comprise full verbatim accounts, as conversational fillers, pauses and discussions that I considered not relevant to the research activity were excluded from the accounts

Sound quality of the recordings also affected some aspects of the transcription. In light of errors found when reviewing the transcriptions, I took a pragmatic decision to prioritise, ensuring the transcription was 100% accurate for data cited in the thesis, rather than spend time on further rechecking the whole data corpus.

It is also important to note here that the primary set was not complete when the analysis started. One data item, the adult interview with the Healthy Schools Coordinator from the Health Education Service (HSCHEs) was still outstanding, but secured and incorporated before Phase 2 was completed.

Prompted by Braun and Clarke (2006), I asked myself two key questions during Phase 1:

1. *What are my initial analytic interests or thoughts?*

- What do data say about psychosocial aspects of the impact of service provision for childhood obesity in schools?
- Are there significant differences between children's and adults' views?
- What are the tensions, if any with regard to strategic guidance and operational ethos of the HSP?
- Do the data say anything new in light of the existing literature review?

2 *What meanings and patterns emerge from the initial reading of the data before coding?*

Here, the following three patterns of meaning suggested themselves:

- Parents and primary aged children see the focus of the National Healthy Schools Programme (NHSP) predominately as healthy eating and physical activity. The emotional well-being and PHSE (Personal, Health, and Social Education) threads are not as well considered.
- Schools acknowledge that the issue of "unintended harm" may not have been fully considered in the drawing up of action plans and provision. However schools have confidence that current systems can address any negative impact.
- Different views are held by adults and children, with regard to the extent of weight bias and stigma in the form of bullying behaviours in schools.

**6.4.2 Generating initial codes (Phase 2):** *Coding interesting features of the data in a systematic fashion across the entire data set, and collating data relevant to each code*

As indicated above I took an inductive approach: codes were generated as the primary data items were read and reread using the NVivo 8 software. During this phase I re-read each data item 'officially' three times. The only exception was the outstanding adult interview with the HSCHEs, which was 'officially' read twice. I further reread particular sections of interest within the data sets. During the second official reread I felt it was important to make active efforts to clarify the meaning of the codes to reduce duplication and attempt more relevant renaming of the generated codes. I repeated this process during the third official reread. During the coding activity the highest numbers of codes generated and used was 132. By the end of the 'official' third reread there were 115 codes.

During and by the end of the third official reread I reviewed the 115 codes that I had generated and carried out an exercise to see which codes were clearly linked to, or informed by, the research questions, theory and the literature review, and which codes could truly be classed as inductively derived, i.e. linked to new ideas that the data had generated. In Appendix 6.4 there is the list of the 115 codes generated at this point of the analysis. I have highlighted the codes I considered inductively derived. This distinction generated a very small percent of 'inductive' codes. The codes that emerged revealed that my

approach was more ‘theory-driven’ and influenced by deductive frameworks including my own worldview.

A researcher’s preconceptions and values form just one level of subjectivity with regard to the researcher’s interaction with the data. For example I was very conscious during the first and second official reads that I was trying to ignore my own verbal contributions in the data. I would only code my input as a means to provide context to participants’ responses if what they had said was ambiguous without this approach to coding.

However, I considered my own responses should not be ignored as part of the data set and so I coded ABLPs’ (Attitudes Beliefs and Learning Points) where I saw myself gaining insight through the discussions and also moments where my own attitudes and beliefs were coming into play that were likely to have had an overt impact on a participant’s responses.

#### **6.4.3 Searching for themes (Phase 3 Part 1):** *Collating codes into potential themes, gathering all data relevant to each potential theme*

It was at this point that I started to make changes to my hybrid thematic analysis framework. My experiences to date made me appreciate that until I had incorporated the secondary sources of data through the next template phase, I risked being premature in making definitive decisions about themes. I thought it would be more useful to collate the data into hierarchical levels,

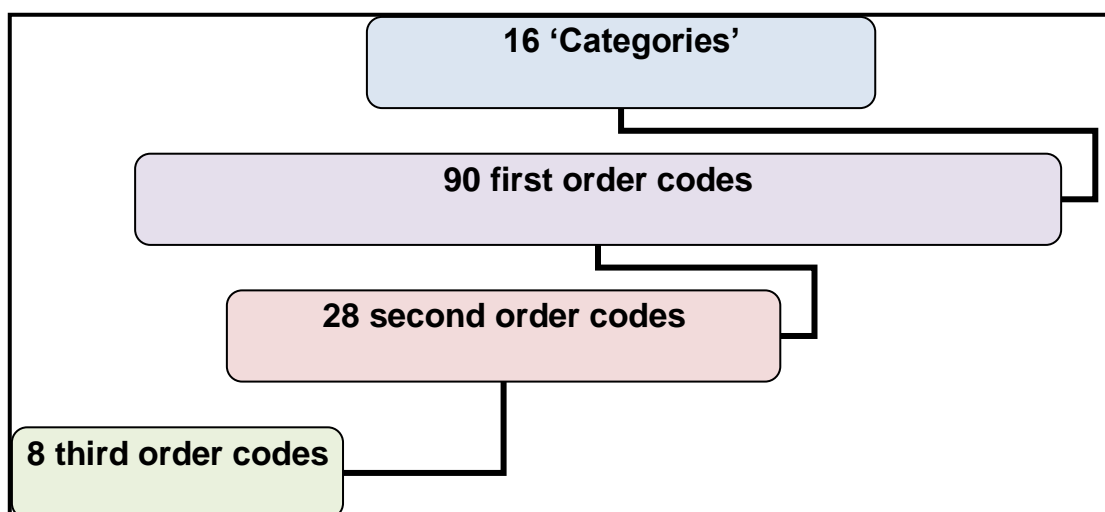
finishing with higher order of 'categories', rather than themes. Consequently this phase was split into two sub-phases.

The first sub-phase entailed reorganising and collating codes: this was facilitated by the use of the 'tree node' function of NVivo 8 which helped me to collate the codes into a hierarchy of first, second, and third order codes. The first order codes formed the majority and these were finally connected to 16 categories as summarised, in Table 6.3. Appendix 6.5 gives an overview of how the 115 codes are connected to the 16 categories.

<b>Table 6.3 The 16 categories developed through the first sub phase of phase 3 of the Braun and Clarke's (2006) thematic analysis model</b>		
1. Comparatives	6. Force Field Analysis (FFA)	12. Partners
2. Concerns about Obesity	7. Food and Eating	13. Physical Education (PE)
3. Children and Young People (CYP)	8. Healthy School Programme (HSP)	14. Provision
4. Every Child Matters (ECM)	9. <u>Inclusion</u>	15. Psychosocial correlates of obesity (PSC)
5. Ecological Transactional (ET) System	10. Learning Points (LPs)	16. Weight Status
	11. Measures	

Figure 6.2 below represents a summary of the number of categories and codes at the different hierarchical levels. It is important to note that the categories and the code hierarchy itself were not mutually exclusive, as I wanted to incorporate codes where relevant into more than one category or hierarchical level to help with the evolution of potential themes hence 126 codes are represented in Figure 6.2 and Appendix 6.5.

**Figure 6.2 Summary of the hierarchy of categories and codes in Phase 3 Part 1 of Braun and Clarke's (2006) model**



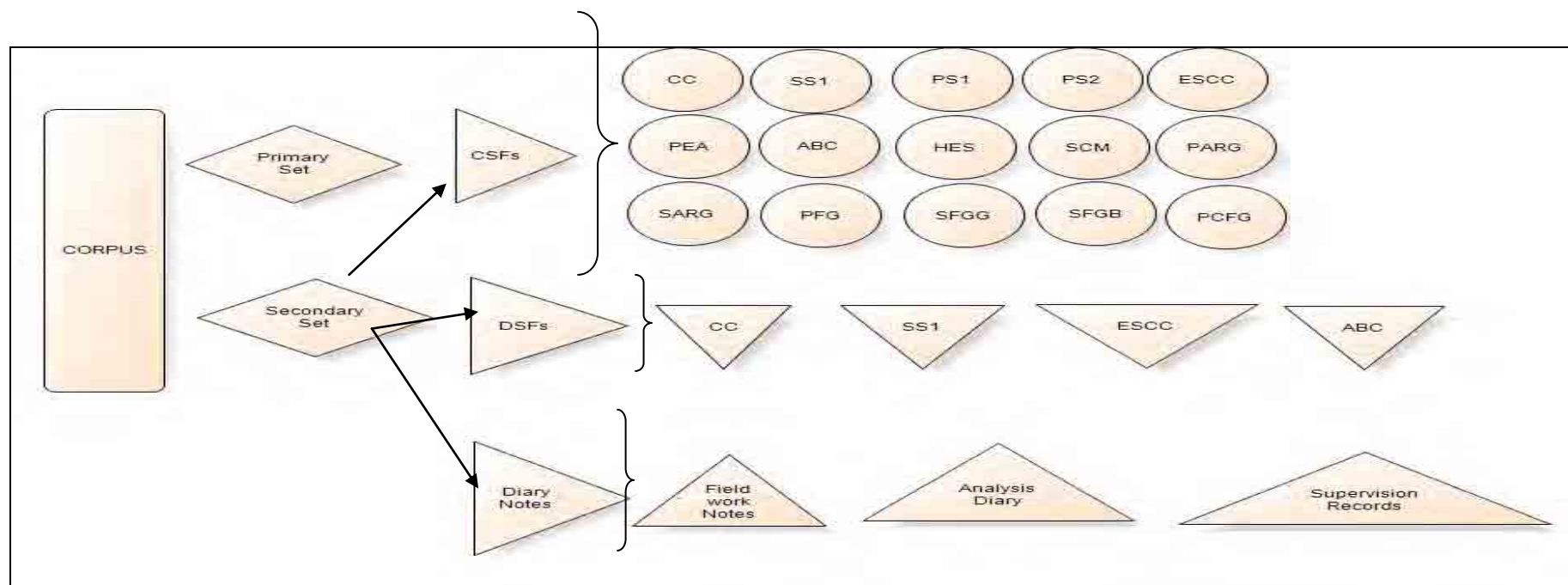
#### **6.4.4 Template analysis of the secondary sources of data**

As illustrated in Fig 6.3 below, the secondary sources comprised 22 data sets that were grouped into three main types of source:-

- contact summary forms (CSFs);
- document summary forms (DSFs); and
- 'diary' notes, including supervision records.

Examples of completed CSFs, one DSFs and extracts from 'diary notes' can be found in Appendices 6.6, 6.7, and 6.8 respectively.





**Figure 6 .3; Secondary sources of data**

**Key:**

CSFs -Contact Summary Forms

DSFs- Document Summary Forms

See Figure 6 .1 for primary sources of data

CC1 - Children Centre, SS1 – Secondary School 1, 1 PS1- Primary School 1,  
 PS2 - Primary School 2  
 PEC - PE Consultant ABC Anti- Bullying Coordinator,  
 HES - Health Education Service (Healthy Schools Coordinator)  
 SCM - Sports Centre Manager, PARG- Primary Advisory Reference Group,  
 SARG - Secondary Advisory Reference Group, PFG –Primary Focus Group,  
 SFGG - Secondary Focus Group Girls, SFGB – Secondary Focus Group Boys  
 PCMG - Parent/Carer Meeting Group ESCC – Extended Services Cluster  
 Coordinator

Figure 5.1 (page 164) in the previous chapter illustrated the planned steps for this template analysis based on King's (1998; 2004) model. Table 6.4 reiterates the stages involved.

**Table 6.4 Template analysis stages based on King's (2004; 1998) model.**

1. Refamiliarization with the data set and defining the use of the 'a priori' themes and codes
2. Coding of sources with the 'a priori' template that may lead to revised and new codes
3. Grouping codes into higher order codes which describe broad themes in the data
4. Developing and finalising the 'a priori' template of themes

The categories (Table 6.3) and the related codes became the 'a priori' template to analyse the secondary sources of data. Step one and two of the template analysis, which entailed familiarization with and the coding of, the data sets using the 'a priori' template of categories, took a shorter time to complete compared to the coding of the primary sources of data. Due to the nature of the categories template, stage three did not involve a grouping process to create another hierarchical level of codes. Rather the focus became a review of the whole hierarchy of categories and codes that led to changes to the template through mergers, deletions and name changes.

For example, in coding my primary data, I had created the field force analysis (FFA) category to bring together the data that represented promoting and inhibiting forces with the cluster ascribed the capacity to impact on the outcomes of provision. On reflection I felt all the codes, primarily the second order codes could be differentiated into two new distinct groups.

The first group including codes such as 'Mutual Support' and 'Disordered Eating' could be used to create a new category, 'Minimising Unintended Harm' linked to identified risk potentiation and compensatory factors within the cluster.

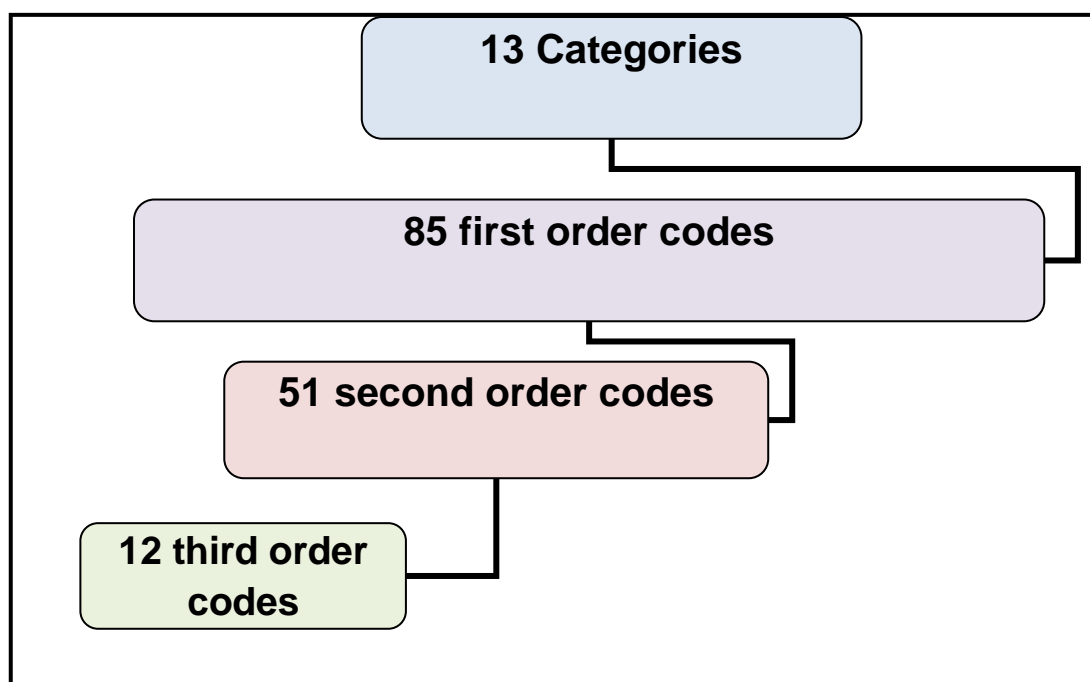
The second group of codes such as 'Coming Together' and 'Conflicts and Tensions' more aptly highlighted the partnership activities taking place within the cluster. Therefore this latter data set of codes was merged into the 'ET System' category via a new first order code called 'Partnership Features'; while the name of the ET System category was changed to 'ETS Roles and Activities'.

There were also slight revisions to the names of six other categories to aid clarity of terminology. Other key changes that took place were the deletion of three categories (Measures, Partners, and Inclusion), through their incorporation into other categories within the code hierarchy. Further attempts were made to make the parallel coding and cross referencing within the hierarchy more robust. For example first order codes under one category e.g. 'Food Menu' became the second order codes for another. Appendix 6.9

provides an overview of the mergers, deletions and name changes of the original 115 codes to reach a total of 108 distinct codes.

Again the hierarchy of codes connected to the categories was not mutually exclusive, since, as was the case with the primary source data analysis described earlier, I wanted to incorporate the codes where relevant into more than one category or hierarchical level. This revised template now entailed 13 categories with 107 distinct codes which, when parallel coding was taken into account, created 145 cross-referenced codes (see Appendix 6.10). Figure 6.4 above provides a revised summary of numbers of categories and the mutually inclusive codes at the different hierarchical levels while table 6.5 provides an overview of the changes between the original and revised categories.

**Figure 6.4 Revised summary of the hierarchy of categories and codes in at the end of the template phase**



**Table 6.5 Initial and revised categories developed through the template analysis framework**

**Key: *Stayed the same.* Changed to.**

1. Comparatives
2. Concerns about Obesity
3. Children and Young People (CYP)
4. Every Child Matters (ECM)
5. Ecological Transactional (ET) System
6. Field Force Analysis (FFA)
7. Food and Eating
8. Healthy School Programme (HSP)
9. Inclusion
10. Learning Points (LPs)
11. Measures
12. Partners
13. Physical Education (PE)
14. Provision
15. Psychosocial correlates of obesity (PSC)
16. Weight Status

1. *Comparatives*
2. *Concerns about Obesity*
3. CYP's Perspectives
4. *Every Child Matters (ECM)*
5. ETS Roles and Activities
6. Minimising Risk of Unintended Harm
7. Food, Eating and Diets
8. National Healthy Schools Programme (NHSP)
9. *Learning points (LPs)*
10. PE and Sport
11. Models of Provision
12. *Psychosocial correlates of obesity*
13. Measures of Weight Status

With this level of the coding for the primary and secondary sources of data and their collation through abstraction of 'categories' I saw Step 4 of this template approach as redundant. The end of Step 3 was a logical point to return to complete Phase 3 of Braun and Clarke's (2006) model, positioning the revised categories now as sub-themes for further analysis. Figure 6.5 overleaf shows the template analysis process as it was amended from its original conception described in the previous chapter (p164).

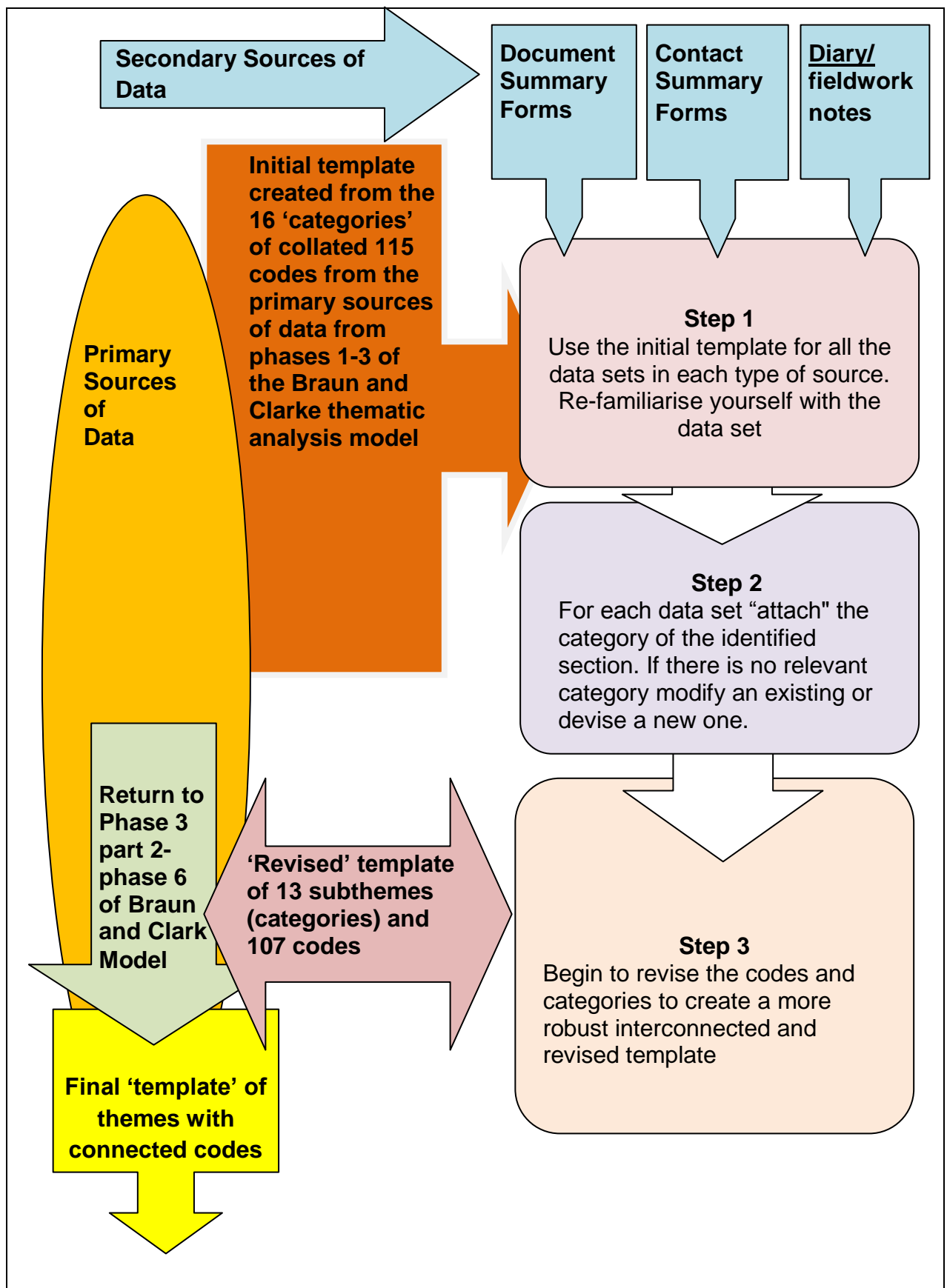
#### **6.4.5 Searching for themes (Phase 3 Part 2)** *Collating codes into potential themes, gathering all data relevant to each potential theme*

The primary objective for this phase was for the revised template of categories/sub-themes to generate larger themes (Braun and Clarke, 2006). The first step would be again to clarify again and make more explicit the links between the research questions and the revised template of categories/sub-themes. Some categories/sub-themes were connected to more than one research question. Table 6.6 overleaf shows my initial interpretation of that relationship during this phase and how this process led to the generation of four broader themes which were:

- coming and working together;
- perceptions of and priorities for 'good health' for children and young people ;
- 'unintended harm' – risk potentiation and compensation factors; and
- next steps.

The next two phases would test the validity of the emergent themes.

Figure 6.5 Amended hybrid thematic analysis model.



**Table 6.6 The relationships between the research questions and the revised template of categories/sub-themes**

Research Question	Categories	CONNECTED EMERGING THEMES
4. <i>What are the approaches that are being promoted by partners, particularly schools, within an Extended Provision Cluster regarding the prevention and management of child and adolescent obesity?</i>	Comparatives Concerns about Obesity ECM EST Roles and Activities Every Child Matters (ECM) Food, Eating and Diets NHSP PE and Sport Models of Provision Learning Points (LPs)	COMING AND WORKING TOGETHER  PERCEPTIONS AND PRORITIES OF 'GOOD HEEALTH' FOR CHIDLREN AND YOUNG PEOPLE  DEFINING AND CREATING A ' NEXT STEPS
5. <i>Do the shared and differential perspectives on policy and practice indicate how such initiatives serve to address and prevent potential negative psychosocial outcomes?</i>	Comparatives ECM EST Roles and Activities Food, Eating and Diets Learning Points (LPs) PE and Sport NHSP Psychosocial correlates of obesity (PSC)	PERCEPTIONS AND PRORITIES OF 'GOOD HEEALTH' FOR CHIDLREN AND YOUNG PEOPLE  UNINTENDED HARM – RISK POTENTIATION AND COMPENSATION FACTORS
6. <i>What are the experiences and views of children and young people on childhood and adolescent obesity and on the role and impact of initiatives such as the HSP which is considered a key vehicle for schools to prevent and reduce childhood obesity?</i>	CYP Perspectives Comparatives Concerns about Obesity Learning Points (LPs) Food, Eating and Diets NHSP Minimising Unintended Harm Models of Provision Psychosocial correlates of obesity (PSC) Measures of Weight Status	COMING AND WORKING TOGETHER  NEXT STEPS  UNINTENDED HARM – RISK POTENTIATION AND COMPENSATION FACTORS



**6.4.6 Reviewing themes (Phase 4):** *Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis*

The evident relationship between the research questions and the themes did raise challenges that my analysis approach, in developing the categories /sub-themes, could be considered an exercise in categorizing collated data of interest for ready access and examination, rather than interpreting data. The predominantly descriptive rather than interpretative terminology of the categories reinforced this challenge. The way I endeavoured to address this was through a thematic map (see Table 6.7), illustrating the relationship between themes, categories/subthemes and the key codes from the hierarchy that influenced their emergence.

Again prompted by Braun and Clarke, I saw the end of this phase signalling the end of my search for themes. There were no additions or deletions to the original themes. Acknowledging King’s counsel that the search for ‘final themes is never done’ (1998; 2004), I believed that my own analysis was good enough to support the move to the next phase of ensuring clear and identifiable distinctions by defining and naming themes.

**Table 6.7 The Thematic Map**

able 6.7 The Thematic Map hemes	Categories/Sub-themes	Key codes	
<b>COMING AND WORKING TOGETHER</b>	CYP Perspectives EST Roles and Activities NHSP Models of Provision PE and Sport	<ul style="list-style-type: none"> <li>• Partnership Features</li> <li>• The Role of schools</li> <li>• Parent/Carer and Families roles</li> <li>• Policy Drivers and priorities</li> <li>• Holistic Model of NHSP</li> <li>• External Partners</li> <li>• Internal Partners</li> </ul>	<ul style="list-style-type: none"> <li>• Model of PE Provision</li> <li>• CYP consultation experiences</li> <li>• Conflicts and tensions</li> <li>• The Role of the EPS</li> <li>• The Role of HES</li> <li>• Cluster data</li> </ul>
<b>PERCEPTIONS AND PRORITIES OF 'GOOD HEEALTH' FOR CHIDLREN AND YOUNG PEOPLE</b>	CYP Perspectives Comparatives Concerns about Obesity EST Roles and Activities Every Child Matters (ECM) Food, Eating and Diets Models of Provision NHSP PE and Sport	<ul style="list-style-type: none"> <li>• Holistic Model of NHSP</li> <li>• Age differences</li> <li>• Universal Provision</li> <li>• Targeted Provision</li> <li>• Whole School Approach</li> <li>• Healthy Eating</li> <li>• Physical Activity</li> <li>• Emotional Well Being</li> </ul>	<ul style="list-style-type: none"> <li>• Specialist Provision</li> <li>• Holistic Model of NHSP</li> <li>• Signposting</li> <li>• Policy Drivers and priorities</li> <li>• Healthy Schools and SEAL</li> <li>• CYPS ideas about NHSP</li> <li>• PHSE</li> </ul>
<b>UNINTENDED HARM – RISK POTENTIATION AND COMPENSATION FACTORS</b>	CYP Perspectives Comparatives Food, Eating and Diets Learning Points (LPs) NHSP PE and Sport Psychosocial correlates of obesity) Unintended Harm Measures of Weight Status	<ul style="list-style-type: none"> <li>• Absenteeism</li> <li>• Body dissatisfaction esteem and image</li> <li>• Aversion to PE</li> <li>• Bullying and Teasing</li> <li>• Diets and weight loss</li> <li>• Disordered eating</li> <li>• Diversity and size acceptance</li> <li>• Gender differences</li> <li>• Unsympathetic support for change</li> <li>• General support for OW/OB CYP</li> <li>• Holistic Model of NHSP</li> </ul>	<ul style="list-style-type: none"> <li>• How serious is the issue of obesity</li> <li>• Inclusive practices</li> <li>• CYP support roles</li> <li>• Perceived vs. real weight</li> <li>• Emotional impact of obesity</li> <li>• Self Esteem</li> <li>• Surveillance, pressure, spotlighting</li> <li>• Role of Staff</li> <li>• Parents/Carers and Families roles</li> </ul>
<b>NEXT STEPS</b>	EST Roles and Activities Learning Points (LPs) Models of Provision NHSP PE and Sport	<ul style="list-style-type: none"> <li>• Next steps for providers</li> <li>• Conflicts and tensions</li> <li>• Delicacy of Obesity</li> </ul>	<ul style="list-style-type: none"> <li>• Impact of research activity</li> </ul>

**6.4.7 Defining and naming themes (Phase 5):** *Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.*

Before focusing on specifics, it is useful to return to the prompt questions about meanings and patterns that I asked myself in Phase 1 of the analysis process (page 175). As indicated below, there were no significant change to the patterns, just clarification and some development.

- *Parents and primary aged children see the focus of the Healthy Schools Programme predominately as healthy eating and physical activity. The emotional well-being and PHSE threads are not as connected.*

This interpretation remained through the analysis. Within the mesosystem of the cluster under scrutiny, stakeholders had come together. However the collaboration had not necessarily led to a joined up 'holistic' model of 'Healthy Schools' as shown by the interpretations of the major service users.

- *Schools acknowledge that the issue of "unintended harm" may not have been fully considered in the drawing up of action plans and provision. However schools present as confident that current systems are addressing any negative impact.*

Providers and service users have awareness of some negative phenomena in their systems. However children and young people appear to show more sensitivity to the extent of certain phenomena and how these may be linked to one another. Approaches to strengthening the existing and potential new risk compensation factors could be further informed by improved awareness and understanding of the factors potentiating unintended harm within systems.

- *Differential views are held by adults and children, with regard to the extent of weight bias and stigma in the form of bullying behaviours in schools.*

This premise remained throughout the analysis. Adults and children demonstrated different views about the phenomenon of weight bias, particularly within the microsystems of schools within the cluster.

The additional patterns and meanings that emerged alongside the above will be explored through the four superordinate themes which are defined below and should provide the overall story of the analysis that will be discussed in greater depth in the following chapter.

#### 1. Coming and working together

This theme captures the roles and activities of the stakeholders in the mesosystem of the cluster. The positioning of children and young people as

well as their parents/carers is considered. Potential tensions within service delivery are also highlighted.

2. Perceptions of and provision for 'good health' for children and young people

This theme attempts to capture the perspectives of stakeholders on the nature of 'Healthy Schools'. The impact of provision as a result of dominant themes relevant to the construct of health and well-being is considered.

3. 'Intentional and Unintended harm' – risk potentiation and compensation factors

This theme highlights the interactive forces of intentional discriminatory acts such as weight bias and how they can be compounded by the unintended consequences of health promotion agendas such as the healthy school program. The risk potentiation and compensation factors identified by stakeholders with regard to unintended harm are explored.

4. Next steps

This theme concerns stakeholders' views on future working within the cluster in relation to the National Healthy Schools Programme. The research activity also highlighted potential gaps that should be addressed to inform future thinking and practice.

## 6.5 Conclusion

I consider the use of this hybrid thematic framework based on Braun and Clarke's (2006) thematic analysis model and King's (1998; 2004) template analysis an example of how a pragmatic paradigm facilitated the bringing together and ongoing adaptation of tools to achieve a comprehensive analysis of the data.

A key lesson within this process was my recognition that, despite an initial stance of using an inductive approach to the data, the research questions and the existing literature review proved the key drivers in coding the data. In addition, the 'deficiencies' of the human as an analyst listed in Table 6.1 (p170) raised by Robson (2002) and the constraints that can arise when using computer software to analyse data had were indeed evident during this process. However, the recursive nature of the analysis approach gave opportunities to address some of problems and barriers that arose.

Overall, I would contend that the themes generated through my analysis are 'good enough' to proceed to the final phase of this analysis framework where they will be discussed with reference to the data and the literature. Further reflections about this analysis stage will be shared in the second discussion chapter when methodological strengths and limitations are considered.

## CHAPTER SEVEN: DISCUSSION PART ONE REPORT OF THE FINAL THEMES

**“I firmly believe that writing up should be seen not as a separate stage from analysis and interpretation but rather as a continuation of it.”**

**[King 2004 p267]**

### **7.1 Introduction**

The following two discussion chapters serve to tell two interrelated stories. Part one is focused on achieving the sixth and final phase of the Braun and Clarke (2006) thematic analysis model. Part two entails further reflections on key methodological considerations from the study.

Braun and Clarke (2006) describe the final phase of their thematic analysis model as:

**“PHASE 6: Producing the report:** *The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis”* (p87).

The themes were derived from the previous analysis phases and were informed by the research questions which are shown in Table 7.1 overleaf. The ‘report’ is achieved by a discussion of the four themes listed on pages 191 and 192, with

reference to the literature and original data. Some of the subheadings used in this discussion also reflect some of the key categories and codes that influenced the emergence of the final themes.

**Table 7. 1 The research questions**

1. What are the National Healthy School Programme (NHSP) initiatives promoted by partners, particularly schools, within an Extended Provision Cluster with regard to the prevention and management of childhood obesity?
2. Do the shared and differential perspectives on policy and practice indicate how such initiatives serve to address and prevent potential negative psychosocial outcomes associated with childhood obesity?
3. What are the experiences and views of children and young people on childhood obesity and on the role and impact of initiatives such as the National Healthy School Programme (NHSP)?

The four themes abstracted from Phases 1-5 of the Braun and Clarke (2006) model are discussed in the following order:

1. Coming and working together;
2. Perceptions of and priorities for 'good health' for children and young people;
3. 'Unintended harm' – risk potentiation and compensation factors; and
4. Next steps.



The preceding chapter has already given an account of the definition of these themes (p191-192). Whilst these themes should reflect distinctiveness in their accounts, it would be misleading to ignore how they interrelate. The analysis process highlighted the connectedness of the themes through the parallel coding that took place. King (2004) also warns that whereas using themes to structure accounts leads to clear and succinct thematic discussion, there is the danger of drifting towards generalizations, and losing sight of the individual experiences from which the themes are drawn.

## **7.2 Theme 1 : Coming and working together**

### **7.2.1 Partnership activities between adult providers**

This theme of 'coming and working together' was a likely outcome of the analysis. Adult stakeholders in the cluster were positioned as 'partners' as indicated by my first research question. The cluster was also conceptualised as a mesosystem to illustrate the relationships and transactions between and within microsystems in the cluster, as illustrated in the Methodology Part One Chapter (p113). The literature review had also highlighted multiagency working as a key feature of the national government strategy for the childhood obesity agenda (Cross Government Obesity Unit, 2008).

Analysis of the data confirmed that participating providers voiced the need for, and importance of, working with other partners within and across systems. Partners were viewed as including parents/carers and professionals within the Primary Care Trusts (PCTs) and the Local Authority (LA) to support NHSP initiatives.

*“The ‘Westfield’ extended provision cluster of schools are working together to support the development of the National Healthy Schools Programme, contributing to improving the physical and emotional health and well-being of their children and young people.. ..... For the last twelve months the ‘Westfield’ Cluster has worked extremely hard to develop their partnership work and to improve the outcomes for children and young people”* (Document Summary Form (DSF) – Community Cohesion Article provided by ESCC)

*“Schools will be encouraged to set up some sort of steering group with people from across the school so that a wide range of people are involved in it. ...it is a whole school approach and it’s not one person, you know, beavering away in their classroom trying to do it all, because you don’t have that impact then.”* (Health Education Service Healthy Schools Coordinator- HESHSC)

*“I think that what we have done really well to make this really successful ....., I think our sort of partnerships and involvement of parents and consultation with them have been really strong.”* (Children’s Centre Healthy Setting Coordinator - CC1)

The data suggested a range of approaches used by adult providers to promote and develop their partnership and transactions within the mesosystem.

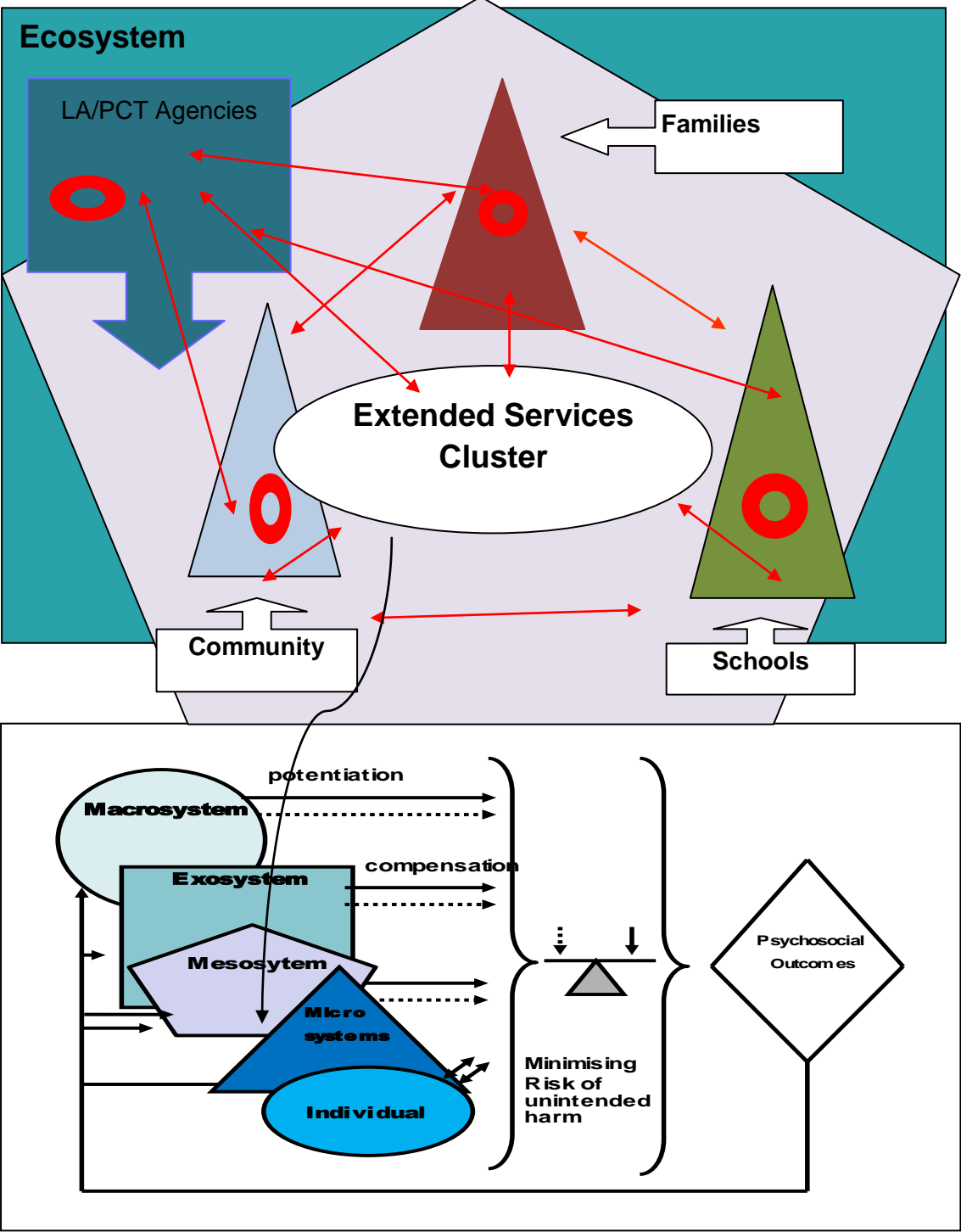
Himmelman (2002) describes a developmental continuum of strategies partnerships use to work together that I have used to depict the approaches used in the cluster. These are:

- *networking* (e.g. sharing information through cluster meetings);
- *coordinating* (e.g. the cluster coordinator and healthy school coordinators meeting with providers to promote access to services);
- *cooperating* (formal agreement through the cluster's action plan); and
- *collaborating* (shared facilitation of activities and training for staff across the cluster).

Reflections on the transactions within the cluster led me to reconsider my initial interpretation of its mesosystemic nature within an ecological transactional model. This mesosystem does not just serve to connect key microsystems, it is also the vehicle by which certain exosystemic influences can have more active impact within the mesosystem and individual microsystems through similar transactions of networking, coordinating, cooperating, and collaboration. One such example, is the LA health education service cooperating with the healthy school coordinators in the cluster to support the planning of interventions. Figure 7.1 below may provides a better representation of the complex nature of transactions within this cluster.

Figure 7.1 Extended Services Clusters as Mesosystems – revised ET model

Transactions within  and between  systems



### 7.2.2 Policy drivers and priorities for partners

The data showed there were multiple agendas bringing partners together that were not always centred around achieving explicit outcomes with regard to healthier weight status for children and young people. For the participating schools policy drivers were mainly about achieving the broader health promotion gains from, and accreditation by, the NHSP (Barnard et al., 2009).

*“Well, initially, it was to get Healthy Schools status, and that was the crucial thing. When we first started, five years ago, five or six years ago, the school was in special measures. There were a lot of things that we didn’t do well. And one of them was getting accreditation for lots of different things. So I pulled together certain key people in the school to try and get that status.”* (Secondary School 1 Healthy School Coordinator- SS1)

*“Part of Extended Services Cluster Coordinator’s role was to analyse local data, prioritising the highest health needs within the Westfield area. General health is not good here and childhood obesity is high. It was decided by the cluster’s multi-agency Steering Group that, as a group of schools, achieving and maintaining healthy school status would be a priority, assisting part of the ‘be healthy’ development within the cluster’s action plan.”* (DSF – Community Cohesion Article provided by ESCC)

*Outcome - That CYP are aware of the importance of healthy life styles and can make informed choices in relation to health and well-being. (DSF Westfield Action Plan provided by Extended Services Cluster Coordinator)*

These last two comments invite debate about how partners in health promotion address the conflict of social disadvantage and enabling healthy choices to reduce health inequalities. Differential access to forms of capital means that some individuals are not able fully to participate in practices deemed the “right” choice (Rawlins, 2009). Adult studies have highlighted barriers such as financial access and availability with regard to healthy food choices (Friel et al., 2006); thoughts about the future (Wardle and Steptoe, 2003); and poor health literacy skills that impact on individuals’ abilities to seek, interpret, critically analyse and use information to make informed lifestyle decisions (Edwards et al., 2009).

Oliver and colleagues (2008 p1), through their systematic review of research on health promotion, inequalities and young people’s health concluded that health promotion, particularly when it uses social and structural interventions developed by multi-disciplinary teams working with young people, not merely for them, has the potential to reduce health inequalities among young people immediately, and in their later lives”. For this cluster there is evidence of multi-agency involvement, albeit in less formal alliances than teams. As highlighted below, the developed and developing interventions appear to be created for, rather than, with children and young people.

For the following participants the emphasis was on a universal holistic health promotion model:

*“I mean, well obviously it is not always when you are thinking of Healthy Schools, it is not about children who are just obese” (ESCC)*

*“...we are talking about healthy eating: it is not just about combating obesity and it is about the holistic approach to healthy eating...” (CC1)*

Priorities were also influenced by perceptions about the extent of the problem of obesity in schools and this appeared to be judged by its visibility. For example:

*“I don’t think we’ve had a massive problem of obesity in the school. I think the fact that, I mean I don’t know, I haven’t got any instant data to back this up, but I would think if anything it’s probably the other end of the spectrum where people are sort of undernourished.” (Secondary School 1 Coordinator- SS1)*

It could be argued that such a narrow focus on the physical manifestation of childhood obesity to judge its significance as ‘a problem’ ignores the complexities of the phenomenon including psychosocial correlates (Puhl and Latner, 2007).

Contact with participants generated reflections as to whether my research activity was making childhood obesity within the Healthy School Programme more, and possibly unnecessarily, explicit for participants than their previous position.

*“I mean if we sat down and said okay we’ve got a problem with obesity; what are we going to do, I think all the measures that we’ve put in place for different reasons would help with that. So we’ve almost done it accidentally if you like possibly” (SS1)*

Consequently such explicitness about a focus on obesity prevention and reduction could also bring the associated sensitivities to the forefront.

*Head articulating that she was not keen on obesity having an explicit focus again in the school with children. Felt all covered with their healthy eating and physical activity (Contact Summary Form – Primary School 2)*

### **7.2.3 Physical activity, Physical Education (P.E.), Sport and childhood obesity—perspectives of key partners**

For those participants who had a role in the promotion of physical activity, P.E. and sport, there appeared to be a shared view of how childhood obesity was perhaps unnecessarily dominating agendas.

*“So I think there needs to be less about the obesity and more about increasing the sports facilities with a background issue of obesity.” (Sports Centre Manager - SCM)*



*“...and what I always bang on about is, you’ve got to get them physical, if you want people to be active, and that’s why I have difference on this obesity thing. I don’t like that obesity tag; it’s about them being active.”* (Physical Education Consultant-PEC)

With the interview with the P.E. consultant I explored further the relationship between P.E. and the childhood obesity agenda, to consider whether it had become too intimate and consequently in danger of becoming P.E.’s professional mission (Kirk, 2006; Burrows, 2005). On the one hand, there was the view that obesity was not a headline force within PE:

*“I was at the National PE Conference on Wednesday. It’s a three day course and I was only there for the first day, and nobody mentioned obesity* (PEC)

However on the other hand, childhood obesity was clearly having an influence on policy and funding:

*The original PSA (Public Service Agreement) target about the two hours, when you looked at why it was, they had three reasons for it. One was to compete on the international stage, the Olympics etc. One was the health agenda etc and the other one was to raise the achievement gap. Now which one of those is going to stay with us, it’s the health agenda one which is going to stay with us. So I think it has and I think a lot of money has gone into it and when I’m on courses and I ask*

*people why have they spent all that money the first thing they'll say is obesity, everybody says it because of the media. (PEC)*

Lear and Palmer (2008) state P.E. may have become very strongly associated with the “exercise opportunity” to combat obesity, which could grossly undermine what P.E. has to offer for a child’s overall development. The P.E. advisor gave one example of how efforts to secure new initiatives within P.E. appeared to be influenced by other agendas most probably informed by obesity discourses.

*“So they did yoga every day, and they found a big improvement from it so I put in for funding for it. It got turned down because yoga wasn’t high intensity physical activity, and I thought that was quite narrow-minded. Obviously, it’s a bit like you were saying, well if they’re running around that’s alright but actually isn’t it more important that they can sit still when they want to.” (PEC)*

In light of this I agree with Evans and Davies’ (2004 cited by Burrows and Wright 2007) view that there is a risk that the role of P.E. to achieve the joy and pleasure of finding out how your body can work in ways that may be functional, aesthetic and/or performative (in the competitive sense) could be replaced by a notion that bodies need shaping, training and ‘work’ to achieve an unachievable physical ideal.

#### 7.2.4 Children and young people's consultation experiences

Views of adult respondents and my own prior experiences in the cluster had indicated that consultation with children and young people was an established feature of cluster activity, and hence that children and young people could be positioned as partners. For example, children and young people's views were sought to inform the action plans of the cluster:

*"It came as well really sort of really, from conversations that I had with young people you know about issues that affect them through different stages of their lives "(ESCC)*

*"It has been quite low level. I mean, what we have done. We did a bit of a questionnaire. But that was done quite light heartedly sort of within family group time. And just basic questions you know, about what foods do they eat at Nursery, what do they like about the environment that they eat in. Do we have rules at Nursery, why do you think we have rules?, ... so quite low level consultation really, but then obviously through daily contact with children, just listening to what their interests are around physical activity, eating ." (CC1)*

*"I think there was an element of we know best, we know what's good for them. However, we did go through student voice and we did at that, well we still have, a Schools Council. So we did have discussions with them, and kids always come up with reasons why school food, school meals are not what they would like, what*

*they would want, what they would prefer.” (SS1)*

*“When I came here, our school council we brought this issue to the table and discussed how we could change it and we had a meeting with the head of food who worked in the canteen. And she has changed it and the menu is a lot nicer and healthy. There is a lot of salad and stuff like that” (Secondary Focus Group Boys –SFGB)*

Here, young people agreed that the process of consultation was authentic and that their views were heeded and acted upon. Gaining the views of children provides integral evidence for schools to achieve and demonstrate their NHSP status (Healthy Schools, 2009b). Studies with children that aim to gain their perspectives on the causes and solutions of obesity advocate the importance of pupil participation in planning and evaluating delivery (Booth et al, 2008). However participants’ responses here indicate a more ‘top-down’, adult-orientated approach (de Winter et al., 1999). Systematic reviews suggest that greater success may be achieved by working with young people, not merely for them (Oliver et al., 2008). Stafford and colleagues’ (2003) study with young people on their views about consultation concluded “consulting poorly is worse than not consulting at all” (p372). If general approaches are weak, ensuring the voices of vulnerable groups such as obese/overweight young people’s capacity to contribute to shaping services is further compromised, especially if as Curtis (2008) argues, the NHSP reinforces cultures that serve to silence and devalue obese/overweight young people.

### **7.2.5 Parent/Carers roles and other adult partners**

Parents and carers, when asked to consider how schools were promoting healthy lifestyles through Healthy School programmes reported:

*“Parents feel schools are doing their jobs .....Schools are expected to be all things to all people; however targeted interventions should be the responsibility of parents”* CSF – Parent/Carers Meeting Group (PCMG)

This echoes the themes from the recent Every Parent Matters report (DfES, 2007) which draws on research that found most parents/carers believe that responsibility for their child’s education is shared between parents/carers and schools. According to Pyle and colleagues (2006), the inclusion of a parental involvement component within obesity interventions is “crucial.” The parental role should be “central to the collective efforts to combat the nation’s childhood obesity epidemic” (Lindsay et al., 2006 p.170).

Interviews with the extended cluster coordinator and the children’s centre healthy setting coordinator raised questions about my role as educational psychologist within the NHSP. This research activity was seen by them as a means by which I had positioned myself as having a role within the NHSP in the cluster by asking questions about its impact.

Child and Adolescent Mental Health Services (CAMHS) were also mentioned by the cluster coordinator as having capacity to support cluster initiatives on emotional well-being. However no participant made any specific reference to linking childhood obesity and CAMHS involvement. Despite Chadwick and Crocker's (2005) claim of visible involvement of clinical psychologists, Walker and Hill (2009) argue that there is very little information regarding which, and to what extent, CAMHS, (a primary employer of clinical psychologists), are involved with childhood obesity across the UK.

Overall although the data suggested that partners were coming together to work collaboratively toward shared goals, it was difficult to gain a tangible sense of how the four themes of the NHSP: (physical activity, healthy eating, emotional health and well-being (EHWB), and Personal Health Social Education (PHSE)) were being brought together and integrated through the collaborations in place. I questioned whether for childhood obesity the scope for balanced 'holistic' integration through the NHSP was being affected by the dominance of the healthy eating and physical activity themes. This in turn would reflect the priorities of health when dealing with concerns about weight status as explored in Theme Two.

## **7.3 Theme 2 – Perceptions and provision for ‘good health’ for children and young people**

I have divided discussion of this theme into two sections to aid clarity. The first sub-section focuses on perceptions about the nature of ‘healthy’ schools by participants. The second sub-section focuses on the nature of the provision in place.

### **7.3.1 Perceptions about the nature of ‘healthy’ schools**

#### **7.3.1.1 Defining Health**

‘Health’ and ‘health promotion’ are complex ill-defined concepts (Johansson et al., 2009). Parr (2002 p373) states “Health is never simply ‘health; instead it can easily become a means of moralising, of normalising, and of regulating”. Zanker and Gard (2008) argue the ‘health’ in ‘health promotion’ means medical health. With reference to weight status, normative discourses surrounding health promote the idea of health equaling thin (Rawlins, 2009). As Gard and Wright (2005) have argued, it is difficult to envisage the fat child as anything other than ‘unhealthy’ and/or morally defunct in a climate where fear of fat has reached such epidemic proportions. Burrows and Wright (2007) argue that the sheer range and volume of health promotion initiatives and the diverse philosophical orientations of groups

who seek to work with school-aged children lead to confusion and uncertainty over what counts as good 'health' and how to go about achieving it.

In the White Paper, *Your child, your schools, our future: building a 21<sup>st</sup> century schools system* (DCFS, 2009b), the Labour Government made it clear that it wants to see schools not only providing an excellent education, but also supporting children's wider wellbeing, including their health. The NHSP has the aim of promoting a coherent and holistic message and whole school/whole child approach about the importance of choosing a healthier lifestyle (<http://resources.healthyschools.gov.uk/p/Static/AboutUs>). The 41 audit criteria related to the four core themes of the NHSP provide schools and their partners with a comprehensive template to operationalise the nature of good 'health' in their settings. The guidance to schools stresses the links between the four themes (<http://audit.healthyschools.gov.uk/Themes>). There was evidence that the children's centre was a good example of where this holistic agenda was delivered in practice:

*"I feel quite strongly about that sometimes, some schools are giving out the wrong message about what a healthy setting actually is and it is you know, the healthy eating is not the be all and end all of it all and one of the things that we have stressed in this policy is that you know the most important thing is that you know children are happy, have got high self esteem, and they are confident and that 's when we know we are doing things right."* (Children's Centre Healthy Setting Coordinator- CC1)



### 7.3.1.2 Children and young people's perspectives on health and well-being as defined by the NHSP

The responses by child participants about their understanding of 'Healthy Schools' influenced my own perception of rather more disconnected provision. In the focus group discussions with children, their initial responses to my questions about what they could tell me about Healthy Schools were dominated by the healthy eating and physical activity themes. Table 7.2 for example is a summary of the written responses from the primary focus group in Primary School 1.

Further prompting and donation of examples about non-physical or diet-related health themes (e.g. 'children feeling good about themselves and feeling safe'), led to the inclusion of these further written responses from the children:

- *Children feel safe because the teachers ask them how they feel*
- *(The school) doesn't put children in danger*
- *Making us feel much better about our selves*
- *Teachers at PS1 encourage you so that you can feel more confident*

(Primary Focus Group – PFG)

With older pupils, initial responses were again dominated by the themes of healthy eating and physical activity. However broader aspects about 'healthy schools' were shared with little or no prompting from myself, for example:

**Table 7.2 Responses by Primary Focus Group participants (R1-6): Characteristics of Healthy Schools**

<p>1 hour of P.E. every week R1</p> <p>Salad Bar</p> <p>Going Swimming on Friday</p> <p>Not allowed to have chocolate and sweets in school</p> <p>Healthy School dinners</p> <p>Sport every week</p>	<p>They do healthy activities R2</p> <p>They go swimming</p> <p>They have 1 hour of P.E.</p> <p>We have a lot of sporty things that happen around the school</p> <p>They have vegetable and fruits</p> <p>No sweets aloud</p>
<p>Eating healthy food R3</p> <p>Going swimming</p> <p>Doing P.E.</p> <p>You see children only eating healthy things in school</p> <p>Teachers tell us to go and run and around so we can become healthy and fit</p>	<p>Swimming R4</p> <p>Healthier P.E. lessons</p> <p>Healthy diet</p> <p>Primary School 1 (Coordinator) are planting vegetables</p> <p>Salad bar (at dinner)</p> <p>No junk food allowed (sweets, crisps, fizzy drinks)</p> <p>Sport activities (football gymnastics, netball)</p>
<p>Five a day R5</p> <p>Fruit and veg</p> <p>No fat food or stuff like that</p> <p>At least two P.E. lessons a week</p> <p>When you eat you get to do exercise not just sitting there</p> <p>Healthy food</p> <p>Salad Bar</p>	<p>2 hours of P.E. every week R6</p> <p>Healthy School dinner</p> <p>Sports activities</p> <p>Salad Bar</p> <p>Not allowed to have junk food in their school house</p> <p>Different choices of fruits to eat break and dinner time</p>

*“You can speak to anyone, any member of staff without feeling you are not confident enough to because they are supportive.”* (Secondary Focus Group Boys- SFGB)

*“..Yesterday I heard the girls went down to the hall to talk about cervical cancer. So it is good you can get that education.”* SFGB

*“Also the way that classrooms are set, because it is not healthy for someone to be learning in a classroom they don’t want to learn in”.* SFGG

#### 7.3.1.3 A Holistic Model for Healthy Schools?

My interview with the HES Healthy Schools Coordinator gave some validation of my developing hypothesis that the four NHSP themes were often not being connected and that certain themes had attained prominence over others both for adults and children and young people, as the following quotes attest, respectively:

*I mean I think it is really the connection thing.... there are still some schools or people in schools who ring up and oh we're doing the healthy eating award or something, and it might not necessarily be a teacher who's rung up to say that but, you know, it still has this sort of perception in some places, as you know particularly healthy eating... (Health Education Service Healthy School Coordinator HESHSC),*

*“I think it is more age ... the kids will probably think of it, you know, oh that's SEAL<sup>11</sup> but not really see it as 'healthy', it's SEAL. So it doesn't mean it's not going on and I would say the vast majority of primary schools are much better at addressing emotional health things than secondary schools, but it is, you know, I don't think it really matters what their perception is as long as they're actually being subjected to support in all those different ...” . (HESHSC)*

This perspective appears to be contrary to key tenets of the NHSP that include the promotion of an holistic approach and guidance to demonstrate how the themes are and can be connected. However it was of interest to note that even within a recent interim report of the evaluation of the NHSP, the themes were reviewed separately with virtually no comment on how schools were integrating them.

However there was acknowledgement that the healthy eating theme was dominant over the others (Barnard et al., 2009). Studies have shown that children and young people's perceptions of health encompass physical *and* emotional well-being (e.g. Warwick et al., 2005). While Piko and Bak (2006) in their Hungarian study argue that primary aged children can demonstrate their understanding of health as a complex, biological, psychological, social and spiritual phenomenon.

The NHSP guidance state that the themes of Emotional Health and Well-Being (EHWB) and PSHE are as important as healthy eating and physical activity themes with regard to childhood obesity. Together the four themes could ensure initiatives are both beneficial and appropriate. The EHWB and PHSE themes

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<sup>11</sup> SEAL-Social and Emotional Aspects of Learning (DfES 2005)

would also afford means for schools to ensure the avoidance of a blame culture that stigmatises those who are obese and overweight (DOH, 2007).

I reflected on the factors within the research study that may have contributed to the dominance to reported physical activity and healthy eating themes within the NHSP. I accepted there was a probability that the questions asked may have led to biased responses, for example, in response to my seeking evidence about activities related to prevention and management of obesity in the semi-structured interviews with providers. I also had to recognise that despite wanting to explore alternative aspects to childhood obesity, I may not have been successful in disentangling myself from the media and political biomedical emphasis on dealing with the physical aspects of the phenomena (de Vries, 2007).

In summary, my experiences in attempting to explore 'holistic' notions of health with regard to childhood obesity had partial resonance with Burrows and Wright's (2007) view that in a context of reported "crisis" within an "obesity-laden environment", much of the focus in schooling remains on practices that impact on physical health, and specifically on eating and physical exercise.

### 7.3.2 Provision to promote 'good health' to address childhood obesity

#### 7.3.2.1 The role of schools

Schools have been regarded as important settings for universal health education and health promotion since the 1950s, both in the UK and worldwide (Lister-Sharpe et al., 1999). The NHSP launched in 1999 has moved from a locally-based to a national programme:

*The Government set a target of 75% of schools to achieve that standard (NHSS) by December (2008). And again people were sort of a bit horrified to think that that was a sort of target for a non-statutory scheme. However nationally that target was hit in May last year (2008), and as such it is the only voluntary, if you like, programme of its nature that's ever reached its targets that early, and therefore the Government have seen schools as being increasingly important in delivering the sorts of, I suppose, health messages that they want delivering, because they can see that so much progress was made in such a relatively short time by so many schools that they think now that Healthy Schools can continue to be that key deliverer in basically addressing all the health needs of everybody around the country, etc."* (Health Education Service Healthy School Coordinator-HESHSC)

The interview with the Health Education Service Coordinator suggested the differential journeys of individual schools in the local authority reflected the

evidence emerging from the national picture of the impact of the NHSP with regard to the motivations and the process of change undertaken by schools (Barnard et al., 2009).

#### 7.3.2.2 Universal provision

All the participant adult providers in the cluster confirmed their view that their primary role lay in universal healthy lifestyles promotion for children and young people in their care within the cluster. This universal position also influenced their perspectives on how explicit was their commitment to address childhood obesity through prevention and management in driving their provision:

*“Obviously we are aware of, you know, the government agendas and everything but, I don’t know, maybe it is because we are early years but I mean, in terms of, you know, sort of other services we offer, obviously we have got targeted groups, teenage parents, that sort of thing, but I think in terms of this, obviously staff have got the awareness of the obesity thing but I think we feel our role is that universal role and to just encourage that healthy approach really”* (Children’s Centre Healthy Settings Coordinator –CC1)

*“I would say universal. We have not got (NHSP) status and I think until you’ve got the actual thing that’s when you start to think well we’ve got the heading, how small is that, so how can we expand on that further, and we’re still in the process of getting it.”* (Primary School 1 Healthy Schools Coordinator – PS1)

Systematic reviews have attempted to identify the impact of universal provision on levels of childhood obesity in the school setting (Dobbins et al., 2009; Jaime and Lock 2009). They have demonstrated positive effects on improving the nutrition, physical environment and lifestyle behaviours (e.g. diet and levels of sedentary activity); however there has been no documented impact on weight status using BMI measures. Overall, as concluded by Brown and Summerbell (2009), such diverse and inconsistent findings, make it difficult to generalize about the efficacy of obesity interventions within the context of universal provision.

#### 7.3.2.3 Targeted and specialist provision

One community setting that was under scrutiny in this study, the sports centre, also had a principle of universal access. However this setting did have another role in provision, as it was the site for a PCT-funded and targeted intervention for children (ages 9-13) who were overweight and obese. This was the 'WATCH IT' intervention.

WATCH IT offers a model for a community-based service for obese children (Rudolf et al., 2006). Dixey and colleagues' (2006) evaluation of WATCH IT indicated measures of success such as recruiting and retaining children; children's enjoyment of the sessions; and meeting their emotional needs. However Dixey et al (2006) agree the evidence base is still patchy, which has also been highlighted by other commentators (Aicken and Roberts, 2008). The Head of PS2 cited the



less than positive experiences for some ex-pupils and their parents who attended the WATCH IT intervention in the cluster as one reason why the school did not want to have an explicit focus on obesity again, including participation in my own research.

The school settings in the cluster did engage in NHSP targeted interventions, which commonly took the form of physical activity initiatives. However obesity reduction is currently not an explicit focus for those interventions; gender, age or special educational needs were the common examples of target populations given.

My discussion with the cluster and healthy school coordinators explored their views as to whether they saw their settings at the time, or in the future, also being sites for targeted or even specialist interventions for children for whom weight status was a concern:

*“I think a lot of schools are used to signposting, you know and I don’t know if schools are ready at the moment to take that on that as a full responsibility (targeted intervention for overweight or obese children). To a degree they do, you know maybe at a lower level but if the family, you know and young people need more sort of intervention, support there, then they will signpost but that is just because of the way it has been.”* (Extended Services Cluster Coordinator –ESCC)

For the children's centre coordinator there were similar concerns about moving into more specialist territories. On the one hand there was acceptance of the centre's role in working in partnership with specialist providers, but discomfort about:

*"...how that is actually done" (CC1).*

For Primary School 1 (Coordinator) there was a clear view that parents had primary responsibility where there was a need for more targeted or specialist interventions;

*"Because we try to make it more about the parents because the children at the moment I don't think they're really got, because they're so young, they haven't got a choice of what they're eating, it's more the parents" (PS1).*

Schools moving to more targeted approaches will be explored further in the last theme of 'next steps'. In general, there is consensus that schools are only part of a bigger picture. The NHSP guidance and commentators (e.g. Nuffield Council of Bioethics, 2007) consider it unreasonable to expect interventions in schools alone to be sufficient to reduce the prevalence of obesity. This point serves a useful reminder that there is a complex social ecology surrounding the childhood obesity agenda. The strengths and limitations of schools in identifying and delivering models of provision will be influenced by the strengths and limitations of the interconnected nested systems of the family, community, strategic policy and

practice alongside the contributions individual children bring into the ecology via physical, psychological and social factors (O'Brien et al., 2007a).

If holistic and more sensitively attuned models of 'good health' are to be considered for the range of needs of children and young people where perceived or real weight status is giving cause for concern, a starting point should be developing and negotiating consensus between systems on the nature of the holistic model being used to enable positive outcomes. However as highlighted in the exploration of risk potentiating and compensatory factors within systems below this may not be straight forward.

## **7.4 Theme 3: Unintended harm – risk potentiation and compensation factors**

### **7.4.1 Unintended harm – summary of current evidence base**

Unintended outcomes of well intentioned health promotion initiatives in schools have been considered by commentators (e.g. Brownell et al., 2009). In general the literature does not yet offer a consensus about which messages should be used to decrease the risk of obesity without causing stigmatization and labelling of children whose weight status is causing concern, and without leading to adverse psychosocial side effects (van Wijnen et al., 2009). O'Dea (2005) highlighted that well-meaning health education initiatives and health messages may elude the

target audience and may have adverse outcomes, for example in generating disordered eating practices, particularly among girls (O'Dea and Maloney, 2000). Larkin and Rice (2005) identified five specific limitations of the healthy eating, healthy weight approach used in the school curriculum:

- (1) it sends contradictory messages;
- (2) it increases anxieties about body weight;
- (3) it ignores the multiple causes of eating problems;
- (4) it marginalizes issues most relevant to racialized girls; and
- (5) it ignores dilemmas associated with physical development.

However Carter and Bulick (2008), through a systematic review of studies, argue that existing evidence does not support the view that childhood obesity prevention programs are associated with unintended psychological harm. Carter and Bulick (2008) also comment, however that because psychosocial variables have been so poorly assessed within these programs, conclusions about their possible inimical effects are premature. The need for a more comprehensive assessment was also acknowledged by Krukowski and colleagues (2008) whose US study found no change to the levels of weight-based teasing following the initiation of an obesity prevention programme.

I hoped the data would reveal risk potentiation and compensation factors that could be mapped onto the amended ET model described in Figure 7.1 (p199). I defined potentiation and compensation factors as those aspects within the

mesosystem that were likely to generate (potentiate) or reduce (compensate) for risk of psychological or/and psychosocial harm, in particular unintended harm. In reviewing the data, I considered the following four potentiation and three compensation factors the most salient.

#### **7.4.2 Risk Potentiation factors**

##### **7.4.2.1 Negative phenomena such as body dissatisfaction and unhealthy eating exist within systems**

*“There was some very interesting pre discussion while the girls were waiting. I would say they could be considered as presenting with ‘healthy weights’; however they engaged in a discussion about not eating food, weight “do you think I am fat” to each other. (Contact Summary Form – Secondary Focus Group Girls-SFGG)*

Nichter (2000) coined the term “fat talk” to represent girls’ seemingly ritualistic conversations about being too fat. Many boys and girls aspire to very lean body shapes that are unattainable and likely to be unhealthy (Rees et al., 2008).

Sweeting and colleagues (2008) concluded from their Scottish study that many obese adolescents appear unconcerned about their weight, although a significant minority of the non-obese worry needlessly. In contrast, Goldschmidt and colleagues (2008) state that disordered eating attitudes and behaviours appear to be quite common in youth, and overweight youth have been identified as a subset

of the population at particularly high risk for endorsing such symptoms (e.g. Nuemark-Sztainer et al., 2006, O'Dea and Maloney, 2000).

There was acknowledgement by adults and children who took part in the study of food/weight- related practices giving cause for concern such as over-concern with food choices, body dissatisfaction, and disordered eating. For example:

*“Children are hearing and repeating the messages from school “it is junk” “this is not healthy”. Some of these messages had to be moderated by parents e.g. “you can have this food sometimes”* Contact Summary Form – Parents Meeting Group

*“They are getting more scared right. Oh my God, am I getting, am I really that fat? You see boys, right sometimes they go say right sometimes to Y and me they do call us fat and ugly. We can get paranoid and we have got to wear makeup to make us look prettier and we have got to lose weight. I am skinny but because people tell me you are fat. And I am thinking to myself I am not fat though. Now I have started to do jogging and my mum says stop doing jogging you don't need to. My mum says just ignore boys.”* (SFGG)

*“Because we had that (diet practices causing concern) in Year 5 last year. We had to get the nurse in to talk about it.”* (Primary School Coordinator-PS1)

*“We have had some children that have been, some girls we’ve been concerned about in terms of eating disorders; rapid weight loss and that sort of thing.*

(Secondary School Coordinator-SS1)

*“I do have a friend, and she likes eating but on school dinners she hardly eats.*

*(someone asks who is it and the female participant says she is not telling) And she doesn’t eat and then she says when I go home I eat and then she likes running around every time, every two minutes, up and down. And then she says I want to lose weight, ...” (PARG)*

*“Say like you are getting bullied and they say that you are obese it might lead to a fight and in their head they might think that shall I change and get anorexia and that.” (Secondary Focus Group Boys-SFBB)*

*“Some people who are like skinny and I am telling you skinny, they are my friends, they are bones, and like they like “Oh I am fat, I am going to lose weight. I am like - get a life they are so stupid” (SFGB)*

These alarming reports of children and young people’s skewed attitudes to food, their bodies, the desire for the thin ideal, the influence of peers via teasing and perceived surveillance, are a cause for concern.

This study has reflected trends similar to other research findings reported by others including young people’s awareness of the association between body

dissatisfaction and disordered eating practices of their peers (Mooney et al., 2009; Evans et al., 2008; Lieberman et al., 2001). I also hypothesized that in the systems under scrutiny in this study, in particular amongst the adult stakeholders, obesity and eating disorders are positioned as separate entities rather than on a spectrum of weight-related problems with shared risk factors, as advocated by Haines and Neumark-Sztainer (2006). This separation of weight status concerns creates potential for further exacerbation of all weight/food related phenomena, especially within a context in which one aspect of the spectrum is the target of intensive political, social and media scrutiny and intervention.

#### 7.4.2.2 The potential for adverse unintended outcomes may or may not have been sufficiently considered in the planning of initiatives

There was a range of responses illuminating this topic from participants, from proactive agendas to afterthoughts prompted by the research activity:

*“We have got a member of staff here and her little girl at her school they are doing the healthy setting award and it is quite clear that they are very hung up on this healthy eating, to the extent that she has she has not wanted to go to school, she has not wanted to use the toilets there. And my concern listening to her was actually it is doing more harm than good. So I think we have been quite conscious that’s what we wanted to avoid here.” (CC1)*



*“So I think it (risk of unintended harm) was thought out, but it was thought out maybe across the city really, as a whole, that we all needed to address the issues of the Healthy Schools and how we are supporting that process. So I do believe that we did. It was considered and is considered to a degree”* Extended Services Cluster Coordinator-ESCC)

*Yeah, because we hadn't really thought about that when we sat down when we started. Maybe it's something we should have mentioned. But then again these are some of the things that happen that come down the line you think well next time”* (PS1)

It was surprising and concerning that despite the reported awareness of negative phenomena in school settings, there appeared to be little concrete evidence of proactive approaches to ensure the health promotion interventions minimise such risk. Probable reasons for this stance are over-confidence in the integrity of a well-intentioned intervention and perhaps over-reliance on compensatory factors such as established support systems which are discussed below.

The lack of action about the potential risk of harm within health promotion initiatives appeared to be not just a matter of confidence in current provision but attributable to respondents' limited recognition of the extent and importance of possible negative outcomes in the system. This is tangibly demonstrated by the varied perspectives about weight stigma and bias in the system.

#### 7.4.2.3 Varied perspectives about the extent of negative phenomena such as weight stigma and bullying linked to weight status within systems

I chose weight-related stigma and bullying as a focus in this study as the literature review had indicated that schools can be highly stigmatizing environments for children who are overweight or obese (Fox and Edmunds, 2000), and that children and young people are subject to negative bias by peers (Latner and Stunkard, 2003) and their teachers (Pryor and Reber, 2008). Weight status is seen as a predictor of being bullied (Lumeng et al., 2010). Perceptions of the extent of such negative phenomena by participants in the study varied, particularly between adults and children:

*“Agreement that some parents can be negative towards children with regard their weight”* Contact Summary From - Parent Focus Group Meeting

*“This is a newer issue that people are not tackling or something, .... it seems to me that they’re all of equal importance really”. (ABC)*

*“I can’t really think of fat children that are being bullied and are being isolated by others. So I’d like to think we haven’t got much of a problem. I’d hate to be wrong but that’s my gut feeling.” (SS1)*

*“I think, we, certainly in my experience over the last 5 years, we never had, I have never sort of heard of, experienced any sort of incidences where children are being bullied because of size or shape or differences” (CC1)*

There was a mixed response from the PS1 coordinator:

*“I think in secondary because that’s when they get older and that’s when they do start to do that kind of thing isn’t it, whereas at primary school they’re all generally getting on and they know each other well enough.” (PS1)*

*“...I walk around the school and I’m hearing so many things about “you’re fat!” and you look at the child they’re talking about and the child is thin as a rake and I just think well what does that child know about obesity, you know, because if that child’s obese then ....” (PS1)*

Weight-related teasing is prevalent in the lives of young children (Penny and Haddock, 2008; Hill and Waterston, 2002) as well as adolescents (Krukowski et al., 2009). Although higher in prevalence with overweight and obese children and young people, their non overweight peers are not immune (Eisenberg et al., 2006). Such contradictory responses by PS1 may reflect a possible misconceptions about the nature of weight teasing and its common occurrence in a cultural context where ‘fat is bad’ (Puhl and Brownell, 2003).

One possibility is that adults were not defining certain weight-based stigmatizing behaviour as 'bullying' hence their views about its extent in the system. Research has demonstrated teachers' perceptions of bullying behaviour can differ from their pupils' (e.g. O'Brien et al., 2007b; Ofsted, 2008; Glover et al., 2000). Eisenberg and colleagues (2003) argue that even minor slights and teasing can produce considerable distress for overweight pupils. It was also of interest that the adults' responses focused on peer interactions rather than adult roles communicating/contributing to stigma and bias. In contrast, an example of teacher bias was raised in the girls' secondary focus group.

*"And the teacher (from another school) was saying don't pick Z, she is fat she can't run, she runs like a pig and stuff like that." (SFGG)*

There may be an element of denial by adults because the issue is sensitive and therefore difficult to acknowledge. Schools and clusters need to consider whether current consultation processes with children and young people to inform anti-bullying policies and practices are providing an accurate and comprehensive picture of the nature, range and prevalence of their concerns (Naylor et al., 2006).

For this cluster, such a step is important, particularly in light of the disconcerting evidence of the prevalence of weight stigma/bullying shared in the child focus groups. The contrast between adults' and children's perspectives can also be explained by Rees and colleagues' (2008) view that children experience obesity largely as a social problem, as the following quotes suggest:

*“I actually think some children will feel a lot uncomfortable by the way people tease them and say oh you are fat or you are skinny and say that. I really think that it will affect them.” (Primary Focus Group- PFG)*

*“There is boy in primary school and he was obese and he told me personally that he was on a diet. I never told no-one though. And someone found out. Someone heard a conversation and keep calling him fat and made him sad. I don’t want to be on a diet ever because they are going to start blazing him again. He got bullied a lot.” (SFGB)*

*“And you see with bullying. When you are fat now when someone blazes you about your weight it could lead to other consequences like child may say does not want to come to this school no more. They may think of suicide and say I don’t want to face this ... anymore.” (SFGB)*

Research has documented mixed findings regarding whether male and female adolescents express different levels of weight bias and whether one sex is more vulnerable to stigma than the other (Puhl and Latner, 2007). The primary focus group participants had the following perspectives on gender differences in dealing with the phenomenon of weight-related teasing:

*Boys hide it that they feel uncomfortable (R1)*

*Boys feel bad but are just not showing it. (R2)*

*Girls will show it. (R1)*

*The boys that are like obese, they just act as if they don't really care what people think (R2)*

*But I think the boys must be getting get more teased than the girls (R3)*

*The boys like fighting a lot (R4)*

*No. I think if you are obese boy the girls nah I don't like you. But some obese girls some guys might like them. (R1)*

*But mostly I think that it is obese boys feel it more (R1)*

*(Primary Focus Group PFG)*

The secondary aged boys had the following perspective:

*PVB: I was wondering if..... you had an overweight boy or an overweight girl who do you think is likely to subject to more teasing, the boy or the girl*

*SFGB: The boy*

*The boy*

*PVB: The boy? So even though girls worry about it, it is the boys that get the teasing not the girls...*

*SFGB: Boys are more prone to name calling and girls don't*

*It is a bit wrong if you like are blazing a girl if you say look at this girl and that*

*PVB: So it is considered boys do it*

*SFGB: Girls don't really insult each other about their weight*

The research literature suggests that girls show slightly higher rates of victimization and differential experiences linked to their weight status, compared to boys (Gray et al., 2009). Although overt victimization has been documented among obese youth overall, relative to males, obese females are more likely to be the victims of relational forms of aggression including weight-based teasing, jokes, and being called derogatory names (Janssen et al. 2004; Pearce et al., 2002; Neumark-Sztainer et al. 1998). Obese boys are more likely to be both perpetrators and victims of overt (e.g., pushing, hitting) forms of peer victimization (Griffiths et al. 2006; Pearce et al., 2002).

Results from the bullying rating activity, (carried out as a pilot with the advisory reference groups and then, with some revision to content and procedure, with the focus groups) highlighted that bullying as a result of weight was seen as a highly probable factor (ranked either first or second). Weight was considered a higher factor than other factors such as race (both groups), and homophobia (with the secondary focus groups) (DCFS, 2007b).

These results, including the summary shown in Table 7.3 overleaf, need to be considered with caution due to the small number of participants. Also feedback was collated within a context in which negative psychosocial correlates of childhood obesity were being discussed. Conducting the rating activity within a 'neutral context', such as a general survey activity on bullying with other child participants, would have strengthened the reliability of the results. Another limiting factor was a possible lack of clear definition of the phenomenon under study. Vaillancourt and colleagues (2008) have highlighted that children's definitions of bullying may not match the theoretical and methodological operationalizations within the research literature such as intentionality, repetition, and power imbalance. However this positioned mismatch is another reminder of how children's views could be marginalized in research. It is important that children's and young people's perceptions of a phenomenon are taken seriously, irrespective of how others (i.e. the adults) perceive it.



**Table 7.3 Results of Rating Activity of Factors involved in Bullying**

Donated* Factors listed in order according to average rating score				
Primary – 9 Factors rated. Secondary 10 Factors rated				
PARG n=10	SARG n=4	PFG n=6	SFGG n=4	SFGB n=4
Weight	SEN/D***	Weight	SEN/D***	Weight
Race	Weight	Race	Weight	Family
Appearance**	Religion/Faith	SEN/D****	Race }	Race }
Religion/Faith }	Social/Personality	Appearance**	Age }	SEN/D** }
Family }	Gender	Religion/Faith	Social/Personality	Social/Personality
SEN/D***	Family	Family	Appearance**	Appearance
Social/Personality	Race	Social/Personality	Sexual	Sexual
Age	Appearance**	Age	Orientation	Orientation
Gender	Age	Gender	Family	Religion/Faith
			Religion/Faith	Gender
			Gender	Age
<p>*Non donated factors added by participants included;</p> <p><i>Knowledge – how smart you are</i></p> <p><i>The way you act or speak,</i></p> <p><i>Maybe in a funny accent,</i></p> <p><i>Because you are a geek or nerd,</i></p> <p><i>Clothes, and</i></p> <p><i>Money</i></p> <p>**Physical Appearance</p> <p>*** SEN/D – Special Educational Needs/Disability</p> <p>} Tied rank</p>				

Studies have demonstrated that the phenomenon of weight bias and bullying exists, but ascertaining the prevalence, and how they compare to other factors, is still problematic. This is because different types of stigmatizing encounters and biased attitudes have been examined using a variety of assessment methods (Puhl and Latner, 2007), which makes cross-study comparison problematic. However, the phenomenon appears significant: one UK study involving 8,210 children documented that 36% of obese boys and 34% obese girls reported being victims of weight-based teasing and various forms of bullying (Griffiths et al., 2006).

I was also interested in hearing how certain negative phenomena were related to the physical activity theme. In physical activity settings, not only are pupils' bodies on public display, but so are their movement skills and abilities (Rukavina and Li, 2008). Studies have shown that factors such as perceptions about physical ability and teasing impact on children's level of engagement in P.E. (Bauer et al., 2004). Pupils who deviate from the 'ideal body shape or size' and do not display physical competence in a valued sport or activity may be stigmatized (Storch et al., 2007; Pierce and Wardle, 1997).

In the primary focus group, the children commented:

*There was boy, I am not going to say his name, in swimming well every time he stopped because we had to go all the way round. People would laugh at him oh you are too fat you cannot swim. So he stepped out ....*

*I think it is going to be very very hard for them, like obese kids because like if they cannot change properly like*

*They take longer.*

*Yeah they take longer and people will start laughing. Like when they are taking their tops off. They say like ah you*

*Boys in our class when they put on their shorts, some people tease them about their bellies*

*Like we have got this boy called A. Like some of the boys tease him and say you have got. Am I allowed to use this word man-boobs?*

The secondary aged participants also reported similar phenomena:

*“This girl. In P.E. she does not feel comfortable so she is in the outer or back there because people will turn round and look. The truth is I use to pick on her and was not nice to her. ...She does not want to get changed for P.E. she gets changed in the toilet and then she gets ... that is disgusting. So unhygienic” (Secondary Focus Group Girls-SFGG)*

These comments are similar to the perceptions of overweight and obese young people in Curtis' (2008) study on the impact of the NHSP, where these young

people were acutely sensitive to any implied or assumed criticism relating to their body, bodily performance or social practices.

The NHSP does address weight bias and its association with bullying behaviours. There is a principle of a no blame approach in non-stigmatising environments. My interview with the HES Healthy Schools Coordinator revealed that the onus was on schools to demonstrate good practice in this area through one of the EHWB self-audit criteria that would be judged by a quality assurance group, the HES having a major role as illustrated by the following quote:

*“... they have to do is complete a box of information showing how they are meeting each of those criteria, but one of those refers to discrimination and stigmatisation. ...have to provide evidence of they are meeting it.” (HESHSC)*

Consequently there is a less than satisfactory situation in which schools are not directly asked about, and can offer other examples not related to provision around weight status to be judged on. It appears that the Health Education Service also adopts a reactive rather than proactive stance with this potential risk of stigmatising practices in schools. A recent interim evaluation report of the NHSP (Barnard et al 2009) highlighted that the self-validation approach makes it difficult to monitor and ensure the quality of school practices. There were also mixed views on the ability of quality assurance groups to access the sort of detailed knowledge that was needed (Barnard et al 2009).

The child participants tended to describe maladaptive responses by children and young people to weight related phenomena. Currently there is not a clear picture of the range of coping behaviours children and young people adopt in stigmatising environments. Using the coping mechanisms described by Puhl and Brownell (2003b) (already discussed in Literature Review p61-63 ), Li and Rukavina (2009) added gender, personality, perceptions of controllability, self efficacy and parents as factors that also influenced the coping behaviours of children experiencing weight stigma and bias. These will contribute to both the potentiation and compensation factors at the ontological and microsystemic levels of the ET Model.

There also appears to be the perspective from the NHSP guidance that, by schools working to reduce levels of obesity through the physical activity and healthy eating themes, schools can contribute to positive psychosocial correlates: for example the promotion of self-esteem, which in turn, will make children and young people less vulnerable to bullying (Healthy Schools, 2008). Bauer and colleagues (2004) also suggest that addressing weight teasing/bullying will remove barriers that interfere with efforts to promote physical activity and healthy eating. Such perspectives reinforce the notion that all roads in health promotion are underpinned by the core construct of fat is bad (Evans et al., 2008). As demonstrated by one young participant's view of how Healthy Schools could help children who are overweight and obese:

*“People disrespect people for being overweight. And they have got a reason to do name calling, and if they were not overweight they would not be a target for that.”*

## Secondary Focus Group Boys-SFGB)

Young (2007) argues that bullying policies rarely include a specific reference to obesity. There needs to be a consideration within the microsystems of the cluster of how parents, schools, and communities enact policies to decrease or prevent teasing (Libbey et al., 2008). Griffith and Page (2008) state that school anti-bullying policies need to emphasize the commonality of appearance-related bullying and should also focus on the promotion of weight tolerance and reducing the stigma of obesity.

Such gaps in provision as those suggested within the current study are likely to reflect poor awareness and training for staff about what could be done to address such negative phenomena. This can also be seen as another risk potentiation factor.

### 7.4.2.4 The level of awareness and training for systems to address risks of unintended negative outcomes like weight bias.

In response to questions about what systems were doing to address unintended negative consequences, the responses reinforced this orientation to reactive rather than proactive actions:

*“I suppose we could argue that we leave a lot to chance but it’s only a small part of our being, if you like, of our remit so”. (SS1)*

*“...if you look at literature out there there’s literature for including children with autism, there’s literature for this, but there’s nothing that I know about literature for including children who are overweight, a specific programme.” (Physical Education Consultant -PEC)*

*“I mean this kind of suggests that there’s a conflict between the health education agenda and the anti-bullying agenda, and I guess that’s probably true. And whether schools are getting any support with that, I doubt whether they are”. (ABC)*

Given what the research evidence reveals, leaving the prevention or management of the risks of unintended harm ‘to chance’ seems a somewhat naive and less than ideal policy to adopt. Commentators agree that teachers can play a critical role in the enforcement of school-based interventions to decrease victimization of obese youth (Gray et al., 2009; Eisenberg et al., 2006; Neumark-Sztainer et al., 2002). The responses given in the study suggest that teachers are not yet actively primed to take on this critical harm reduction role. Starting points should include reflection on and challenging weight bias and stigma held by staff (Pryor and Reber, 2008).

### 7.4.3 Compensatory Factors

My considerations about compensatory factors also include speculation about the likely impact of their mediating role to reduce the level of risk generated by the risk potentiation factors in the system.

#### 7.4.3.1 Holistic models of health promotion in systems

In light of the discussion on Theme Two (perceptions and provision for 'good health'), I felt that holistic/integrated models of health could compensate for risks within an ET system. A holistic philosophy appears to acknowledge and support the whole needs of a child where weight status is a concern, as expressed by the extended services cluster coordinator:

*"Sometimes if a child is overweight .....we perceive to be an issue is not an issue for them. ... maybe issues are arising because of other young people see them as different and then issues of bullying come up , and then issues of low self esteem for that young person, lack of interest, involvement in other activities because they becoming really sort of conscious of the fact . So it is not about addressing the obesity issue as in losing weight but about seeing the child as a whole really and addressing issues around self esteem, self reliance, being able to support themselves in situations, and really everything that relates to that young person self development, because then if there are issues of obesity and*



*they want to reduce, maybe their BMI, then that outcome, that will follow...”*

(Extended Services Cluster Coordinator-ESCC)

My initial response was support for this stance, which I saw as unfortunately constrained by barriers rooted in a disconnected (not yet) holistic model of health. However as indicated above, with further reflection and reading, I acknowledged that dominant models of holistic health (Dooris, 2009; Lohrmann, 2008; Foresight, 2007, St. Leger and Nutbeam, 2000), are perhaps more multidimensional rather than fully integrated holistic and also do not necessarily have an emancipatory principle of self-determination with regard to size acceptance. Dominant state-sponsored ‘holistic’ health promotion and obesity management initiatives have covert and overt weight status objectives. Clusters and schools as prime agents of national and government initiatives will experience difficulty in seeking out and delivering alternative ‘holistic’ perspectives such as ‘Healthy at Every/Any Size’ approaches (Aphramor, 2008), especially in light of new government agendas as discussed below within the theme of ‘Next steps’.

#### 7.4.3.2 Inclusive practices within settings

The commitment to universal delivery and inclusive strategies can be considered as aiming to promote a non-stigmatising culture in the delivery of initiatives, for example:

*“And that could be more of a potential problem for this, and particularly maybe if we’re looking at obesity, and I know that’s something that schools have struggled with, with NHSS, because they don’t want to have a group of obese children doing something because all the rest of the school will then perhaps notice that, so they’ve looked at perhaps targeting vulnerable groups, I know, I’m just trying to think, I remember one school particularly but because they didn’t want that group to be that obvious, I think they put on some physical activity clubs after school, to which they invited all the kids that they really felt needed to be there perhaps for their sort of weight issues. And then they targeted some other vulnerable pupils, who were slimmer but had a lot of other needs, and it was in a very deprived area, but they put that club on for them in the hope that other people wouldn’t sort of almost see it for what its main intention was.”* (Health Education Service Healthy School Coordinator -HESHSC)

*You know, I saw a lesson in a secondary school last week, and they were doing a running event. Now again that stands out a mile because you’re running down a track, but the teacher was skilled and she was saying to certain individuals, right, how far do you need to start ahead of that person, do you think you can beat them if you start there. Somebody else, right time that. And they’d all got different roles, so it wasn’t just about, you know, well you know who’s fastest before you get on that field anyway, but those different roles were promoting that inclusive part. Do they do that in all secondary schools?”* (Physical Education Consultant-PEC)

*We try to keep them so they don't feel they're a little bit different, which probably is not really the best thing but in other ways you're not picking on them just because they're obese". (Primary School Coordinator -PS1)*

The inclusive strategies adopted within the cluster may have a role in minimising the marginalization of children and young people who are vulnerable due to perceived and/or actual concerns about their weight status. Also, as Gott (2003) argues, by not identifying and targeting explicitly, risks are minimised with regard to the impact of explicit surveillance and intervention for such a vulnerable group. However, my research data suggests that currently those strategies are informed by incomplete knowledge of the nature of potential difficulties overweight and obese children and young people can face as well as the extent to which NHSP initiatives can unintentionally exacerbate the social exclusion of this vulnerable group (Curtis, 2008).

#### 7.4.3.3 Existing general support structures are able to make a response to specific negative outcomes

Adult participants reported their belief that adequate systems were in place if the issue of stigma or weight-related bullying arose in their setting:

*"That's where the Welfare Officer comes in because we have got X in place who can deal with those sort of things". (SS1)*

“I mean as a school we don’t tolerate bullying. So I think if it did come to it, it would be a case of we would believe that child”. (PS1)

However, settings need to consider whether such existing structures are adequately informed by the existing knowledge of the complexities of negative outcomes related to childhood obesity.

The child participants saw themselves and peers providing support to children where weight was concern:

*“So mostly it is me picking her in my group because I don’t like leaving people out”. (Secondary Focus Group Girls- SFGG)*

*“We were at my house and I was weighing myself. I was six stone something. She was bigger than me. And I said just let me see how heavy you are and she said no. I said why? I do feel uncomfortable. ... It does not really matter we are friends. I am not going to tell anyone and she did it. That is not really bad and then I started taking her jogging round and stuff” (SFGG)*

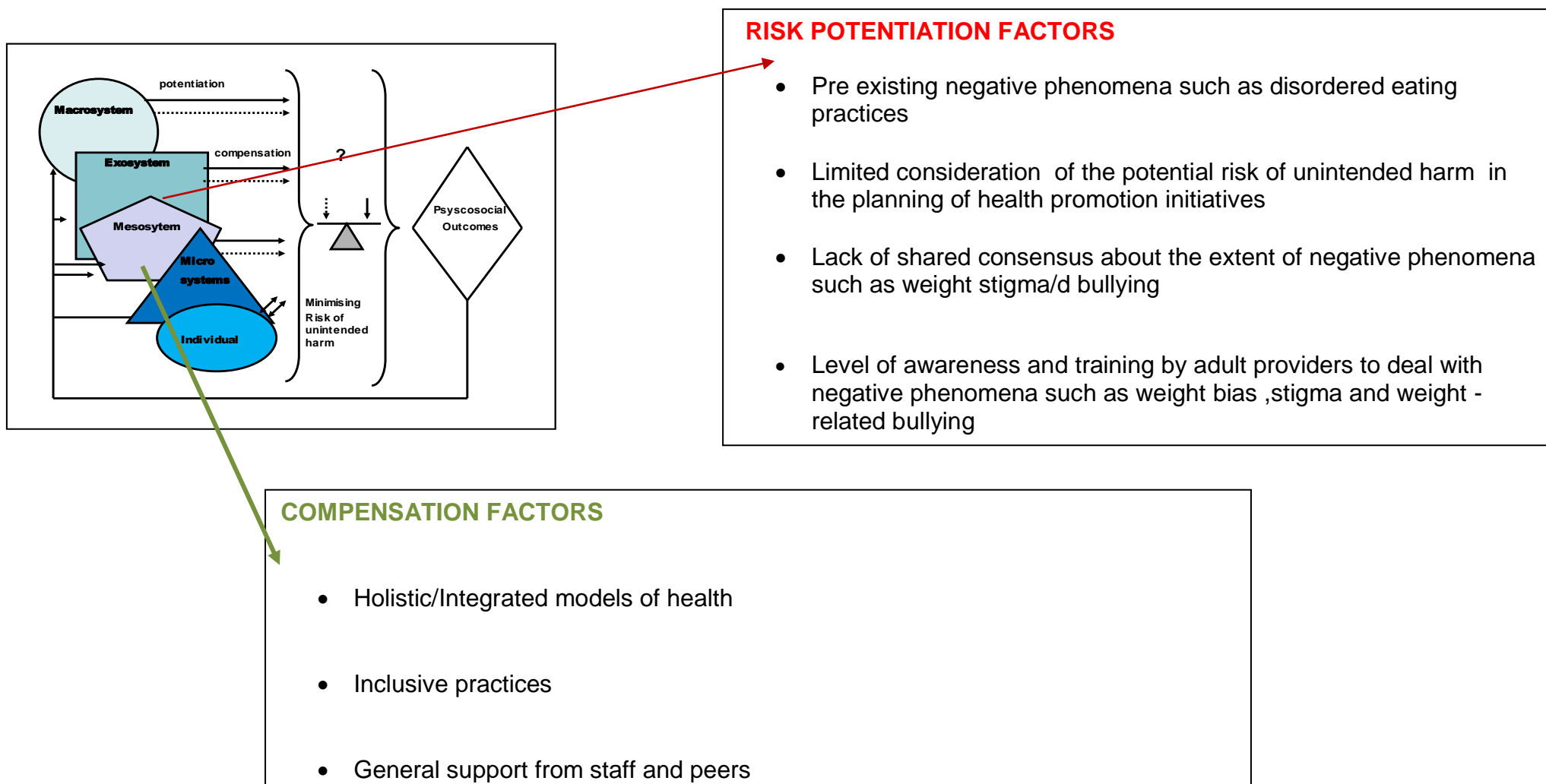
*“We just get along with her and tell her don’t listen to them they are really not that important” (SFGG)*

*“Others will say leave him alone stop the teasing and defend him. “ (PFG)*

The responses of children and young people seemed more sensitive to their peers' needs, especially in relation to psychosocial aspects, than are adults. It was also clear that media played a role in their education. Flodmark (2005) concluded that obese children are helped more by social support than a direct focus on their obesity. The responses here show that the nature of support was not just about dealing with stigmatising or marginalising experiences but also supporting efforts to achieve the 'thin ideal' (Jelalian and Mehlenbeck, 2002). However although friends appear to be a key helpful source of support, this is not always unproblematic (Rees et al., 2009).

I have implied through my data analysis that the compensation factors as they stand could be undermined by the strength of risk potentiation factors. Figure 7.2 attempts to map these factors using the ET model. It is not possible to speculate how much the risk of unintended harm has been minimised through the interactions of these protective factors, as the study has only highlighted part of the story within this ET model. The study's focus on was illuminating potential mesosystemic influences. Whereas there was reasonable data input from schools, the absence of the parent voice and weakness of the community voice has limited discussion and therefore conclusions about their individual and collective contributions to the overall potentiation and compensation of risks arising within the mesosystem.

**Figure 7.2 Summary of the risk potentiation and compensation factors that minimise risk of unintended harm as a result of health promotion initiatives such as the NHSP**



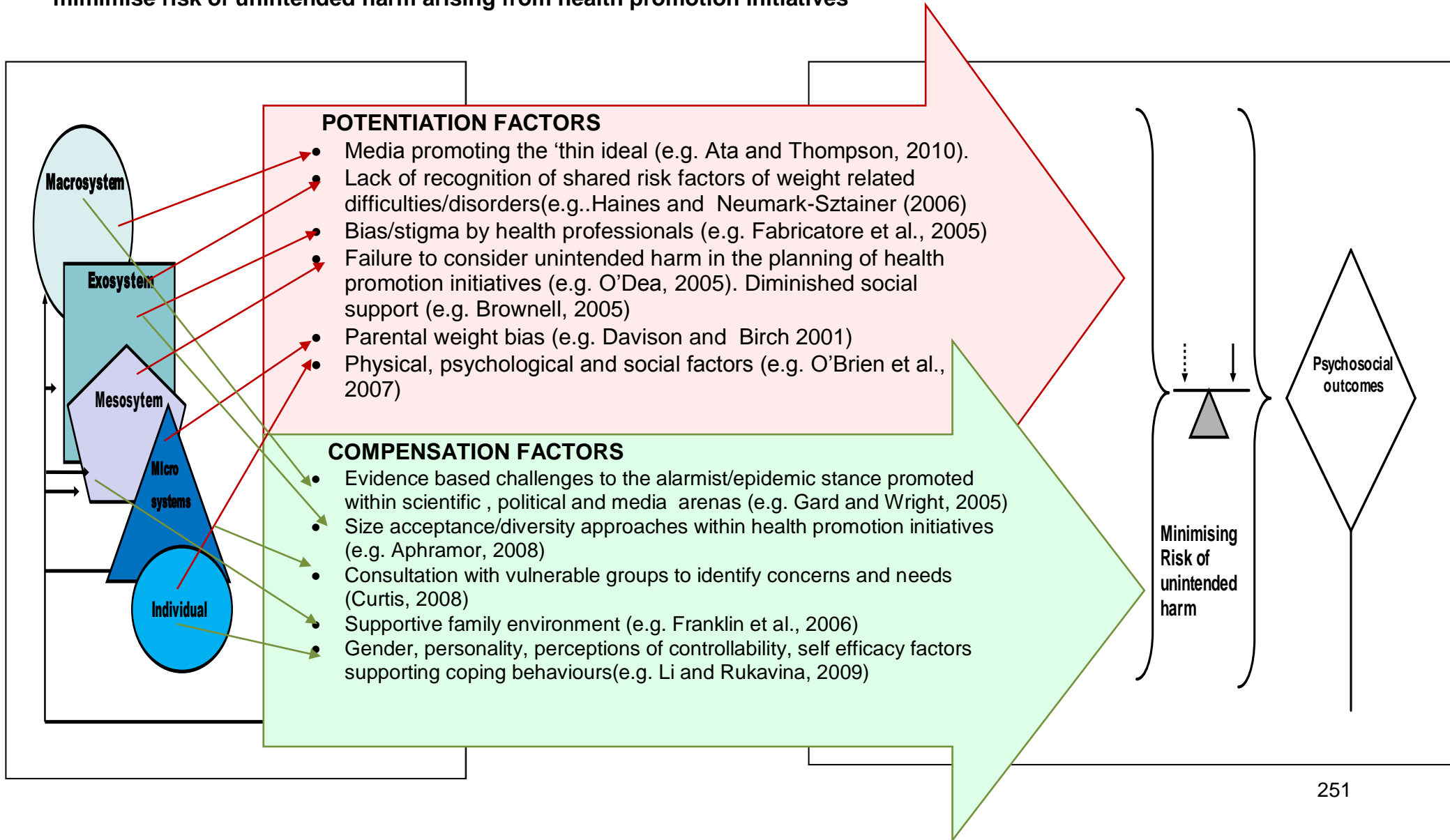
There is also an argument that the influence at the mesosystemic level has to be considered in the context of the roles played by the other nested systems in the model. As illustrated by Figure 7.3, in order to clarify the impact of such gaps, the literature review can serve as a source of examples of potentiation and compensation factors arising within the whole ET model. The success of the NHSP should be judged in part by how far such risk and protective factors are taken into account in the delivery of provision.

As discussed with reference, the following theme, stakeholder' perspectives about the future with regard to the NHSP could indicate whether existing compensation and potentiation factors will be strengthened or weakened.

## **7.5 Theme 4 - Next steps**

The data included some evaluative responses that signalled in some cases, a focus for future developments. For the Extended Services Cluster Coordinator, a primary objective was for all the schools to achieve NHSP status. For the participating secondary school and children centre there was a desire to do more work in the following areas:

**Figure 7.3 Examples of potential risk potentiation and compensation factors highlighted by the literature review that minimise risk of unintended harm arising from health promotion initiatives**





*“If I think of the four areas (healthy eating, physical activity, emotional-well being, PHSE), ... emotional well-being”. (Secondary School Coordinator SS1)*

*“We actually said a couple of years ago, we are trying to do too much, .... We decided for the year just focus on personal and social “(Children Centre Coordinator - CC1)*

It is positive that the focus for these schools signalled a move towards non-physical dimensions of health. However, McLaughlin (2008) considers a potential danger of certain emotional well-being programmes, even SEAL, neglecting social processes in favour of individual factors. McLaughlin (2008) suggests a wider emphasis on relationships, pedagogy and community-building, which could foster work towards an holistic, integrated model of health.

Below are examples of responses, when children and young people were asked directly about ways their schools could further support overweight/obese individuals:

*“Tell them you are not different from any other person”*

*“They should talk more to them about how they are feeling”*

(Primary Focus Group-PFG)

*“Give them more support”*

*“Give them space, if they don’t want to get changed, whether skinny or fat they can get changed in another room”*

*“Bring a packed lunch so people in the hall so others don’t see you eating”*

(Secondary Focus Group Boys-SFGB)

Time factors restricted further discussion with the groups about the nature of support. In hindsight, I would have liked to have asked whether they thought adults were aware of all the issues that they had raised and what were possible universal actions in light of such comments as below:

*“There is generally much pressure on children. They are encouraged too much to be just exactly healthy and to look fit and like that. And people just worry too much and they need to relax a bit more.” (SFGB)*

With regard to strategic developments, the following two areas were of the most interest with regard to the purposes of the study. Firstly, with reference to bullying, the Anti- Bullying Coordinator reported:

*“...and there are some general strategies of prevention and intervention that hold true whatever kind of bullying it is. But at the same time there are also some specific things that would help or could help give advice and information and*

*guidance to people, and I guess we do need to know which are the most prevalent kinds of bullying in order to deal with that, and also we need to know the ways in which the bullying is done, and so I would say that there are some general and some specific things that need to be addressed. So I am interested in looking into it further and I think it would be interesting to know.”* (Anti Bullying Coordinator-ABC)

Currently none of the monitoring measures of bullying used in the local authority allows comparisons of prevalence and/or impact of different kinds of bullying; this would be a first barrier to address in order to move forward to clarify the scale, nature and impact of weight-related and other forms of bullying, and how initiatives increase/decrease bullying.

Secondly, the HES Healthy School Coordinator described noteworthy local developments that were linked to emerging national developments that I had become aware of via the ongoing literature review towards the end of the fieldwork stage of the study. For example, In September 2009 the government officially announced a new phase of the NHSP now to be known as “Healthy Schools”. The new phase is called the ‘enhancement model’, which is seen as the next step for primary care trusts, local authorities and schools previously awarded Healthy School status, working together in addressing ‘specific’ health and well-being needs of children and young people. The Healthy Schools Enhancement Model (HSEM) encourages schools to determine priorities based on a detailed needs analysis linked to national and local drivers; schools are

expected to identify and realize meaningful outcomes through universal and targeted support (Healthy Schools 2009c).

The Health Education Service Healthy Schools Coordinator reported:

*“Now our belief is that almost all the, primary schools, are going to select obesity (reduction) as one of their meaningful outcomes”* (Health Education Service Healthy School Coordinator –HESHSC)

This implies obesity will have a more explicit focus within universal and targeted provision. Currently the Health Education Service is supporting the first cohort of schools in the LA, and the Healthy Schools Coordinator believes:

*“But this first lot of schools, I think, appear to be being very proactive and I think they will come up with hopefully ways of supporting vulnerable groups that are logical or sensible that are not sort of stigmatising them, and hopefully we can learn from that so that by the time we work our way down to schools that are going to be harder work, shall we say, that we've picked up enough information that we will be more able to support and signpost them in the right directions, and help them with dealing with that.”* (HESHSC)

I gained the impression that such a position would be based on the existing ambiguous self-evaluation and moderating approaches, rather than anything new that would more reliably ensure reducing further risk of marginalization for children

and young people who are overweight and obese is contained. The HSEM risks serving further to embed further the social construction of obesity as a problem within the NHSP. The government has claimed schools within the NHSP are world-leading in their creative approach to health promotion (Sangster, 2009). However, I perceive a naivety and continued lack of sensitivity obscured by well-intentioned and/or prejudicial discourses (Rich et al. 2010).

Overall, in summary the findings of the study highlight dominant socio-cultural practices that reinforce the 'thin ideal' and some of the risk potentiation and compensatory factors that could impact on outcomes for children and young people. It would appear the dominance of the 'physical' themes of the NHSP reflect weakness in the operational delivery of a multidimensional rather than a 'holistic' model of health and well-being. The positioned responses in particular by adults indicate psychosocial concerns of childhood obesity are currently a secondary agenda.

There was also a need for me to consider future steps with regard to this research, including recommendations for future research and practice. However before this, it is important to explore methodological considerations, and this is covered in the following chapter.

## **CHAPTER EIGHT: DISCUSSION PART TWO METHODOLOGICAL CONSIDERATIONS**

**“Reflexivity (the critical appraisal of own one’s research practice) must be an important element of any sort of research practice”**

**[Cassell and Symon p5]**

### **8.1 Introduction**

My methodological critique begins with reflections on the position of children and young people in the research, in particular the role of the advisory reference groups. The remainder of the narrative offers short summaries of other key considerations, which include the limitations of the research design. The following topics are suggested as key learning points arising from the data and these are discussed in turn, below:

- The role of children and young people in the research
- Managing the ‘delicacy of obesity’
- Ethical challenges
- Design limitations of the study
- Reliability and validity

## 8.2 The role of children and young people in research

The role of children and young people in research was explored in the Methodology Part One chapter (p104-106). Advisory reference groups were included to realise some of my emancipatory and participatory purposes. The discussion above has highlighted the relatively weak position children and young people occupy in influencing policy implementation and responsive service provision, in comparison to the adult stakeholders in the cluster, as typified by the nature of the consultation processes that had taken place. However research approaches involving children and young people could also be subjected to similar criticism (Morrow and Richards, 1996).

Both the primary and secondary advisory references groups were able to share their perceptions of the nature of 'research' which was rooted in their own learning experiences in school. The secondary aged group were more vocal about their experiences of being involved in research:

SARG: *But it is just like being some kind of test rat or something*

PVB: *...Tell me what you liked about it, about those experiences, and what you have not liked about it. Is that one dislike?*

SARG: *Yes*

PVB: *Feeling like you are a test rat. Any other feelings about what has been good about these experiences and what any other thing?*

SARG: *They want your views. They care about what you actually think*

PVB: *That is a like?*

SARG:        *Yeah*

PVB:        *You like the fact that they are asking you?*

SARG:        *They are not just doing it for themselves*

Theoretical and research developments including legal and ethical responsibilities to uphold children's rights have led to a reported move away from treating children as the passive objects of research (Woodhead and Faulkner, 2000; Sinclair, 2004). Consultation activities, including research, should position children and young people as active participants whose perspectives, views and feelings are respected and valued. Fielding (2004) argues that the 'student as co-researcher' or 'student as researcher' models are the way forward to ensuring a transformative future for children and young people's active participation in research. Kellet (2005) argues that the research methodology known to adults need not be difficult for children to learn. Barriers of age, knowledge and skills can be overcome with innovative approaches.

Co-researcher approaches can be seen as aiming to secure the highest two rungs of Hart's Ladder of Participation (1997) (see p99). My objectives were for the preceding level: 'Rung 5 -young people consulted and informed'. However there were challenges in achieving this objective. I had to consider the extent of my sincerity in involving children in decision making: I was, I realised, open to charges of manipulative self-interested tokenism (Hart, 1992). For example, I was aware that decisions about the parameters for changes to my design were already formulated prior to meeting the groups. I recognised that I would be reluctant to



accept and pursue alternatives to focus groups if these were suggested by participants as options to engage with young people in their schools. I knew also that if the children did not consider my research to be a worthwhile activity, it was unlikely at that stage of commitment that I would withdraw. The young participants' understanding of this power differential between ourselves was likely to lead to espoused support for my research (Mayall, 2002).

Appendix 8.1 provides a summary of the ideas given by the advisory reference groups, highlighting those ideas that were incorporated in the final design. There are examples of both shared and incomplete consensus within the decision making process.

There was also the matter of the role of adults as gatekeepers to the research process. Staff involvement with recruitment, in particular with the primary-aged children, could have undermined children's own rights to decide about participation. I had to ask myself whether I had provided sufficient challenge to staff, or had colluded to ensure children and young people's participation in the research. Heath and colleagues (2007) argue that although children may appear to have been given a choice about participation, it takes courage to refuse in an institutional context, in which consent 'may be based on little more than a desire to please' (Heath et al., 2007 p413) or a fear of potential adverse consequences.

My experiences made me realise I had not considered sufficiently the other gate-keeping roles which adults, particularly school staff, would play in influencing the participation of children and young people beyond eliciting their consent. Leonard

(2005) argues that the Ladder of Participation model by Hart focuses on the power imbalance between child respondent and adult researcher and therefore leaves undeveloped the impact of the power imbalance between adult researcher and adult gatekeeper that affects children's successful participation. Gatekeepers can exercise influence over all stages of the research process.

In my study, there were organisational dependencies such as negotiating acceptable dates for contact with the children and young people. Key recommendations from the advisory reference group such as methods of recruitment had to be subject to further renegotiation with adults. However it would be erroneous to present myself as an innocent party in these negotiations, as clearly I was also advocating my interests as well as seeking to incorporate the views of the children and young people who took part. For example whereas I had attempted to discuss the views of the secondary advisory group on student recruitment for the focus groups with school staff, this was less so with the primary advisory group. Only in retrospect did I recognise that I had tacitly accepted that staff selection rather than open recruitment may form a more effective method to secure children's participation.

Overall, despite questions on how far I had partially abdicated my emancipatory interests through the advisory reference groups, I feel the research study has demonstrated reasonable evidence for Rung 5 (young people consulted and informed) and emergent signs for Rung 6 (adult-initiated, shared decisions with

young people). In future research, a more secure footing on or above rungs 5 and 6 could be achieved by:

- consulting with children and young people earlier in the time frame of the study, to enable them to have a real say in the purposes and design of the research (Stafford et al., 2003) ; and
- multiple contact with the advisory reference group throughout the time frame of the study to facilitate sharing progress and provide opportunities for joint problem solving (Lewis et al., 2008).

Punch (2002) cautions the potential danger that ethical considerations focused on redressing the unequal power relationships between adult researcher and child can create disregard for, or lack of attention to, other research issues; for example, the care needed when interpreting children's views. As Mayall (1994 cited by Punch, 2000), points out, adult researchers' analyses of children's perspectives are informed by different knowledge than that generally available to children. Again multiple contacts with the advisory reference and focus groups to revisit and check my understanding of their views would have afforded one mechanism to attempt to address this risk. Such as step would also, perhaps, have enabled the young people to give fuller or richer information, and would also have contributed to strengthening the reliability of findings through the process of iterative analysis (Fossey et al., 2002). Another option would have been to share

focus group transcripts with the participants for comment and/or iterative analysis of the research data (Forbat and Henderson, 2003).

### **8.3 Managing the ‘delicacy of obesity’**

A key learning point in the study was how research on sensitive topics reveals new insights into, and sharpening of, ethical dilemmas in research (Dickinson-Swift et al., 2008). Edmunds (2008) describes childhood obesity as an extremely sensitive subject for research. The phrase ‘delicacy of obesity’ arose in the interview with the HES Healthy Schools Coordinator to describe how sensitivities around the issue of childhood obesity were preventing access to certain PCT data. I considered this phrase an apt description of my own experiences and difficulties in accessing and gaining data through the research process.

As indicated in the Methodology Part One chapter (p106-108), I had considered and planned for likely sensitivities. My primary focus had been centred on the interaction between myself and the participants during the interviews and group discussions. However I may have underestimated how sensitivities may have affected the recruitment and retention of participants. For example, Powell and Smith (2009) suggest that perceptions by adults that a research project is sensitive, in itself, has an influence on children’s access to participation in research. This could be one reason why the Head of PS2 did not want children to participate in the proposed group discussions. The Head alluded to prior negative experiences of children and families with an earlier obesity-focused intervention.

While it is a genuine concern for children to be protected from any possible adverse consequences of participation, this strong protectionist stance may deny children access to the right to express their views on matters of concern to them (Powell and Smith, 2009).

Then there was the potential impact of my own obese status and its role in the research. Body size and body shape are considered a potential influence on participant responses across a range of research agendas (Barnes and Rosenthal 1985; Miyazaki and Taylor, 2008). In light of the specific focus on obesity, I had taken some steps to deal with this with children and young people in the study (p155) by openly acknowledging my weight status. However in hindsight I may have downplayed the need for similar approaches with adults. Social desirability factors may have prevented participants from sharing openly any negative views on obesity (Collins et al., 2005).

For some participants, their own weight status may also have been an inhibiting factor. There is irony in the deliberate use of the pun 'the elephant in the room' as I recall one interview where the adult participant and I never once verbally raised our status as adults with visible identities of the undesired weight status targeted by national and media discourses that was the focus of our research conversation! I also wondered whether efforts for my story not to dominate the research (Clandinin and Connelly 1994), had led to unwarranted levels of detachment in my reflections and the extent of reflexivity that led to furtive and sanitised approaches (Finlay, 2002). Linked to this is acknowledgement that research is not an emotion-

free experience for a researcher (Hubbard et al., 2001), and the times when I became less subjective were perhaps also times a self-protection strategy was being exercised.

## **8. 4 Ethical Challenges**

The ethical challenges I envisaged having to manage were highlighted in the Methodology Part One chapter, where key ethical considerations were summarised (Table 3.4 p103). Table 8.1 overleaf is a brief summary of my review of those considerations, with an emphasis on key learning points, of which most have been raised in Methodology chapter Part Two. A common theme was that despite commitment and efforts to address potential ethical challenges in my planning, my understanding of ethical issues was essentially theoretical. My interactions in the real world of research determined my practice and pragmatic rather than ideal choices had to be considered good enough. One example of such pragmatism was my accepting alternative routes of consent for certain participants to be involved in the primary focus group (p153-154).

## **8.5 Design limitations of study**

### ***8.5.1 Recruitment and retention of participants***

I have already highlighted in the Methodology chapter Part Two (p156) that not all the targeted adult and child participants agreed to participate. This is turn affected

**Table 8.1 Review of main ethical considerations that arose in the enacted design**

<i>Ethical Considerations</i>	<b>Key learning points</b>
Recruitment of participants	<ul style="list-style-type: none"> <li>• <b>Adults:</b> Respecting the 'voluntariness' of participation. Managing the tension of being a 'insider' practitioner within the setting where the research was conducted and potential conflicts as a result of real or future working relationships with participants</li> <li>• <b>Children:</b> Managing challenges working with adults gatekeepers</li> </ul>
Consent	<ul style="list-style-type: none"> <li>• My dealings with captive audience scenarios e.g. primary advisory reference group and the parent/carer group</li> <li>• Accepting alternative routes of consent such as prior participation and consent to participation another group activity</li> <li>• My management of the role of intermediaries in conveying information about the research and securing consent</li> <li>• My recognition of the need to ensure written information that meet ethical guidelines are accessible to participants who may have literacy or communication needs</li> </ul>
Withdrawal	<ul style="list-style-type: none"> <li>• Having to take the lead in recognising and accepting "passive" as opposed to "active" withdrawal of participants</li> </ul>
Confidentiality	<ul style="list-style-type: none"> <li>• Anonymity was the key mechanism to ensure participants' privacy was protected. The boundaries of confidentiality in particular with regard to safeguarding were discussed with children and young people at the start of the group work</li> </ul>
Detrimental effects	<ul style="list-style-type: none"> <li>• My emphasis had been on minimising potential negative outcomes for participants. However I underestimated the negative impact on a myself in terms of confidence and motivation of managing the operational challenges that arose in carrying out the research as a whole</li> </ul>
Storage and handling of data	<ul style="list-style-type: none"> <li>• Audio recordings and transcripts kept secure. Reflections on electronic storage.</li> </ul>
Harmful or illegal behaviour	<ul style="list-style-type: none"> <li>• The question was raised by one of the potential participants about how this study would not lead to unintended harm and I responded with a defence of actions that would be taken</li> </ul>
Subterfuge	<ul style="list-style-type: none"> <li>• The Healthy Schools Programme was used the vehicle to explore childhood obesity and I did question whether some subterfuge was involved particularly with the primary groups of children. However in reviewing the information sheets and group schedules this connection was made explicit</li> </ul>
Dissemination of findings.	<ul style="list-style-type: none"> <li>• A range of approaches was discussed with participants. Dissemination has not yet taken place. Not all the participants may be contactable so I may have to compromise feeding back to only a representative group of participants</li> </ul>

the quantity and quality of data secured. Also any claim that I had captured representative perspectives within the mesosystem of the cluster could be challenged, in particular the voice of parents/carers. I also needed to mediate the challenging complex dynamic of dealing with the voluntary participation of participants with whom I had an existing or potential future working relationship.

The ambiguity and potential conflict of my multiple roles in the cluster had more impact in practice than I had initially envisaged. As already highlighted in the methodology chapter part two (p145), I may have been too circumspect in making demands, for fear of compromising my existing role relationship and ethical stance.

Stryker (1968) offers a perspective claiming individuals organize their identities in a hierarchy that affects the likelihood that one identity will be more salient than other identities in any given situation. Salience will be determined by the level of commitment to each identity. Commitment, in turn, is shaped by the extensiveness or number of social connections or role partners one has in relation to an identity and the intensiveness or depth of those relationships with role partners. My role as a visiting EP in the cluster was my dominant and established role. My researcher identity could have been strengthened had I taken more advantage of existing opportunities and sought out new means of establishing myself within communities of practice within the University (Shachama and Od-Cohen, 2009). A research design more influenced by emancipatory/participatory principles may



have developed a community of practice of co-researchers in the cluster, rather than the researcher- participant model exercised (Prilleltensky and Nelson, 2002).

### **8.5.2 Interview and focus group design and implementation**

The research activity tested, as well as providing deliberation about, my skills as an interviewer and facilitator. Bryman's (2004) model, based on Kvaales (1996), provides a list of useful criteria to describe the successful interviewer (See Appendix 8.2). In hindsight, it would have been useful to have developed a structured template based on the same or similar criteria to aid my reflections after each interview; to ensure quality development and robustness, to augment my dependence solely on anecdotal/unstructured reflections that were not always followed through.

The content of questions also acted as a potential barrier to effective communication. In hindsight, choosing to gain information about psychosocial correlates solely through questions exploring prevention and management approaches was at times distracting and unhelpful. In most of the interview schedules, questions regarding psychosocial dimensions within the obesity agenda were usually the last questions to be asked. It may have been more fruitful to explore what providers, particularly schools, were doing in general on the EHWB and PHSE themes and to ask participants how provision was meeting the needs of a potentially vulnerable group such as overweight and obese children. The impact of the healthy eating and physical activity themes could then have

been explored within the parameters identified within this initial open –ended inquiry.

Another design limitation was the lack of multiple contacts with participants through the number of interviews and group discussions. This arose through design choices as well as reduced scope for renegotiation, due to time availability being compromised by cancellations and the need to reschedule initial meetings. In light of the sensitive nature of the research topic, multiple contacts may have helped rapport and generated richer and more reliable data. In addition, more contact with the participants over a period of time to revisit and reflect on the impact of research activity in shaping developments within the cluster and schools would have generated valuable additional data.

I also need to consider in light of the sensitive topic, whether I could have used alternative interview techniques to enable participants to feel better supported in sharing views and experiences that may have created discomfort. Hester and colleagues (2009) for their obesity-focused research adopted Solution Focused Therapy techniques, (e.g. solution discourse, the miracle question and scaling) which helped to create a supportive context for problem talk, solutions and successes (Iveson, 2002).

### **8.5.3 Additional operational factors**

The flow of the research was affected by delays due to cancellations, rescheduling and the passive withdrawal of participants. This resulted in part from my dependence on the good will of staff to manage arrangements. I could have incorporated better strategies to deal with the periods of inertia that arose during these times. For example a focus on resolving one particular aspect of the study such as the parent focus group, led to my overlooking efforts to ensure the retention of other participants e.g. the community P.E. lead who had vacated her post when I eventually made contact.

### **8.5.4 Methods of Analysis**

Skills for qualitative analysis need to be learnt alongside the use of 'recipes' (Braun and Clark, 2006). My novice attempts to apply the thematic analysis model revealed weaknesses as well as strengths in use of the approach. My hybrid approach demonstrated fluidity and creativity in bringing together different sources of data for analysis. However the evident influence of the research questions on the nature of the themes abstracted from the data corpus may raise questions about the integrity of my approach.

I had to question whether my dominant use of descriptive as opposed to inferential codes afforded the means for me to seek patterns related to my research questions, rather than seeking out, identifying or ignoring potential new meanings.

In defence, I believe the transparency and outcomes of the thematic analysis process have elucidated further the descriptive patterns that have been generated (Floersch et al., 2010). This in turn has allowed new meaning to be gained from the data as epitomized by the discussion above.

## **8.6 Reliability and Validity**

The data were gained from a narrow group of participants and limited document sources within one extended services cluster. Although it would have been valuable to have secured more participants and secondary sources of information, the small, context-specific sample should not detract from the informative perspectives gained from the study. The findings are consistent with reviews of obesity research focused on the nature of potential psychosocial correlates (Puhl and Latner 2007, Bromfield, 2009), including the positive and negative impact of the NHSP on children who are overweight and obese (Curtis, 2008).

As an exploratory study there was no intent to generalise findings across the cluster or to other populations. However I think the perspective adopted by Curtis (2008) on theoretical generalization can legitimately be applied to my own study as we shared similar aims and purposes in our studies. Curtis (2008) cites Mason who argues ‘the detailed and holistic explanation of one setting, or set of processes, *can be used* to frame relevant questions about others’ (Mason 1998, p. 154).

Groleau and colleagues (2009) argue that if the goal of qualitative researchers is to generate narrative knowledge to effect social change then the problem of generalization has to be resolved in order to allow findings to influence policy and practice in public health. This is a factor to consider in future research in this area if its aim is to influence decision making at a strategic level.

Groleau and colleagues (2009) offer a 'sequential-consensual qualitative design' (SCQD) as a methodological template for qualitative researchers to address this problem. SCQD could be described as a structured triangulated mixed methods approach, as it entails a combination of different qualitative methods such as focus groups and interviews used at various stages of a research project. Each stage informs the next. The authors describe Stage 1 as the cultural voice where focus groups are used to generate initial themes to inform the interviews in Stage 2. The authors describe Stage 2 as the intimate voice, where data gained validate the themes from Stage 1. Stage 3, the political voice involves the themes derived from Stage 2 being discussed in focus groups, including a workshop session with key policy stakeholders and practitioners asked to discuss the data and the recommendations that arose in Stage 2 and 3.

My original planned design, with amendments could have been incorporated into this template as illustrated by Table 8.2 overleaf. The advisory reference groups and dissemination activities could be extended to play a greater role in the research through the cultural and political stages of the research.

**Table 8.2 Incorporating an amended research design into a Sequential-Consensual Qualitative Design (based on Groleau et al., 2009)**

	<b>Stage 1 The Cultural Voice</b>	<b>Stage 2 The Intimate Voice</b>	<b>Stage 3 The Political Voice</b>
<b>Objective</b>	<p>To generate central themes on NHSP and psychosocial outcomes for children who are overweight and obese</p> <p><i>Strengthen internal validity of questions used in Stage 2</i></p>	<p>Using Stage 1 themes and literature review to inform structure of interviews and focus groups</p> <p><i>Provide data with good internal validity and allow comparisons with narratives</i></p>	<p>Validating and presenting themes</p> <p><i>Strengthen external validity of Stage 2 data and produce valid recommendations for health promotion programmes</i></p>
<b>How?</b>	<ul style="list-style-type: none"> <li>• Advisory Reference Groups with <ul style="list-style-type: none"> <li>➤ Adult stakeholders (representative group of Healthy School Coordinators, Community and Parents/Carers)</li> <li>➤ Children and young people</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Individual Interviews with Providers</li> <li>• Document Audit</li> <li>• Focus groups with <ul style="list-style-type: none"> <li>➤ Parents</li> <li>➤ Children</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Advisory Reference Group with children and young people</li> <li>• Bullying Survey in a select sample of schools</li> <li>• Workshop with policy making group e.g. cluster steering group</li> </ul>

## 8.7 Conclusion

These two discussion chapters have shown that the cluster under exploration could demonstrate how their universal health promotion approach particularly within the healthy eating and physical activity themes of the NHSP, aimed to contribute to national and local desired solutions with regard to childhood obesity. It appears that dominance of the 'physical' themes positioned responses to psychosocial concerns as a secondary agenda. The data from the research demonstrated the existence of negative phenomena that comprised risks to the well-being of children and young people where weight status is perceived to be a cause of concern. The ability of systems such as schools to respond to such concerns may be affected by a lack of consideration that endeavours to address childhood obesity, even by universal approaches, can exacerbate existing, and generate new negative psychosocial outcomes. Questions were also raised about the nature and impact of the consultation processes in place with children and young people to influence policy implementation.

The robustness of these conclusions is affected by limitations in the research design such as the number of participants who were engaged. The following chapter draws together the key outcomes from the research process and makes recommendations for future research and practice.

## CHAPTER 9: CONCLUSION

**“In the name of ‘protecting’ children from obesity, policies and practices are emerging that seem to be completely counter to the emotional well-being of children...”**

**[Gard and Wright 2005 p185]**

### 9.1 Overview

Within the social ecology surrounding the childhood obesity agenda, there are voices of disquiet in reaction to the dominant discourses of ‘thin is good, fat is bad’ and demands for curative action. The research that has been commissioned and/or cited to reinforce this dominant position has been criticised for exaggeration and unfounded claims that are in danger of being translated uncritically by schools, which in turn could damage the educational interests and health of children and young people (Evans et al., 2008). Consequently research such as my study that seeks to explore alternative perspectives and question the nature of some of these dominant positions, equally should not be open to challenges of similar weaknesses and potential dangers in its presentation of its findings, and in drawing recommendations for future research and practice.

### 9.2 A summary of the findings from the research questions

1. *What are the National Healthy School Programme (NHSP) initiatives promoted by partners, particularly schools, within an Extended Services Cluster with regard to the prevention and management of childhood obesity?*



The Extended Services Cluster under scrutiny in this study positioned the National Healthy School Programme (NHSP) as the principal means for its schools, with the support of community and strategic partners, to respond to identified health disparities and implement targeted health promotion priorities, including childhood obesity reduction within the cluster. An implicit universal prevention approach to childhood obesity had clearly been adopted by schools with evidence of one community-based targeted initiative for overweight and obese children. The dominance of the healthy eating and physical activity themes of the NHSP was evident when stakeholders and service users responded to enquires about the role of the NHSP and childhood obesity, highlighting an emphasis on the physical aspects of the phenomena.

*2. Do the shared and differential perspectives on policy and practice indicate how such initiatives serve to address and prevent potential negative psychosocial outcomes associated with childhood obesity?*

In general, within the cluster, it appeared that proactive steps to minimise risk of creating or exacerbating potential negative psychosocial outcomes for overweight and obese children were not an explicit or high priority for most providers. A reactive stance to perceived low incidence concerns such as the extent of weight stigma/bullying within systems had been adopted. There appeared to be confidence, as a result of anecdotal reflection rather than an evidence base derived from monitoring, that the well-intentioned aims of the NHSP and supportive cultures were realised within schools, with very little risk of obese and

overweight children being marginalised by the universal NHSP initiatives put in place. It is important to reiterate that the study was only able to highlight negative psychosocial and/or health outcomes, such as unhealthy/disordered eating practices and body dissatisfaction, rather than to secure a measure of actual negative impact on psychosocial outcomes as a result of NHSP activities in the cluster. Even so, responses by providers highlighted naivety with regard to the complex nature of psychosocial correlates and the possible unintended harm caused by health promotion initiatives as highlighted by the literature review. Any move towards proactive responses should first address the somewhat fragmented operationalised holistic model of health that was revealed in some settings, so that it is more sensitively attuned to the needs of children and young people where weight status is a perceived or real concern.

*3. What are the experiences and views of children and young people on childhood obesity and on the role and impact of initiatives such as the National Healthy School Programme (NHSP)?*

The perspectives of children and young people who took part in the study greatly illuminated the dominant socio-cultural discourses that reinforce the 'thin ideal' in school settings. The young participants' views demonstrated some of the risk potentiation and compensatory factors that could impact on outcomes for children and young people who are overweight or obese or have concerns about their weight status, such as weight teasing/bullying experiences. Such rich perspectives appear not be channelled fully into the current consultation

processes with children and young people within the cluster, and certainly had not been 'heard' by service providers or influenced planning, delivery or monitoring.

### **9.3 Final methodological considerations**

The use of a pragmatic paradigm facilitated the exploratory intention of the research. The study did not simply comprise a story of probing a research context but also afforded a means to reflect on the influence of different epistemological positions, and in particular, the nature, challenge and extent of 'outing' my subjectivity within the research (Finlay, 2002). The lessons learnt from the strengths and weaknesses of the design have indicated ways forwards to implement a more robust and comprehensive design such as the sequential-consensual design by Groleau and colleagues (2005) highlighted above (p273) and a co-researcher approach with stakeholders as a starting points. Such designs may be less compromised by operational challenges and will be capable of achieving a complete and more integrated picture of perspectives of providers and service users within health-promoting socio- cultural ecologies.

### **9.4 Original contribution to knowledge and theory development**

This is one of only two known studies in the UK that has focused explicitly on the impact of the NHSP on the experiences of children and young people who are

overweight and obese. This study adds to the body of knowledge on psychosocial correlates of obesity by ascertaining the views of providers at different levels of the social ecology, including the views of a range of children and young people about the real and potential risk and protective factors within that ecology that could affect the outcomes for children where weight status is a concern.

Socio-cultural ecological models are used in health promotion initiatives to provide useful frameworks for achieving a better understanding of the dynamic, complex, contextually-grounded interactions between multiple factors that lead to undesired levels of childhood obesity (Hey, 2004). Such models have focused on developing effective interventions to achieve goals of healthier weight and living (Robinson, 2008). The use of an Ecological Transitional (ET) model as demonstrated in this study can help to shift the focus on outcomes to include the psychosocial well being of the child rather than solely weight status. The ET model provides a useful conceptual framework to explore, make critical sense of, and describe the socio-cultural forces within systems that could on the one hand, marginalize, or on the other, protect the social inclusion and well being of children and young people who have concerns about perceived undesired weight status.

## **9.5 Implications for future research and practice**

As a result of the findings from the study, priorities in the following four contexts are recommended for future research and practice:

### **9.5.1 UK- based research into the psychosocial correlates of childhood obesity**

More research is needed in the UK to explore further both the risk and protective factors within systems that impact on the psychosocial well-being of children and young people who are overweight and obese. A particular focus should be those micro and meso-systems where children and young people are actively involved: their schools, families and the local community.

More research evidence of the prevalence and the nature of weight related teasing and bullying in schools in the UK is needed to inform specific developments within national and local anti-bullying initiatives.

In general the 'hard work, passion and focus' commended by the Government (Cross Government Obesity Unit, 2010 p7), of the partnerships across all parts of society that has led to reported progress with the ambition of maintaining healthier weights in the UK should also be mirrored in multiagency partnerships to ensure psychosocial well being, irrespective of weight status.

### **9.5.2 The National Healthy School Programme**

In general, research needs to take account of the psychosocial impact of the healthy eating/healthy weight status message promoted by national and local

policies, upon the attitudes, self-evaluations and well-being of children and young people across a range of weight statuses. Future evaluations of the NHSP, particularly in light of the introduction of the Healthy Schools Enhancement Model (HSEM) should incorporate closer scrutiny of the psychosocial outcomes for targeted populations, in particular gaining evidence of how settings ensure children who are overweight and obese are not stigmatised by health promoting universal and targeted initiatives within school contexts.

It can be argued that the NHSP is, in policy and practice, more akin to a multidimensional, rather than a truly holistic integrated framework of health and health promotion (Saylor, 2004). Further 'enhancement' developments within the NHSP would be better focused on developing meaningful integration of all four themes (healthy eating, physical activity, emotional well-being and PSHE) as opposed to expanding the parallel and targeted service delivery of the four individual themes.

### **9.5.3 Extended Services Clusters**

Partnership working between stakeholders, and consultation with service users should prioritise achieving consensus about values on 'health' and principles about how an holistic model to inform service delivery should be operationalised and evaluated.

Extended Services Provision should review consultation processes with young people in each cluster to ensure the development and enduring practice of effective and meaningful consultation processes that ensure children and young people's perspectives are heard and listened to (Hill, et al. 2004). There needs to be consideration of how the voices of children and young people who are overweight and obese can be heard, using sensitive approaches.

#### **9.5.4 The role of educational psychologists**

The literature review generated recommendations for future areas of work (p81-82) for Educational Psychology Services (EPSs) and Educational Psychologists (EPs). These remain valid territories in light of the findings of the research, particularly when the above recommendations for research and practice are seen as appropriate contexts in which EPSs and EPs can become more engaged. EPs have the training and professional skills to provide valuable input through an applied and critical psychological perspective about what may or may not help children and young people who are overweight and obese, and indeed, how to protect all children from unintended harm, arising from health promotion endeavours.

A bystander position is no longer tenable if EPSs and EPs claim to want to work "in a creative and innovative way, so as to provide an integrated and coherent perspective of *complex environments.... the complex problems and situations*

which occur in such environments etc and the *complex needs* of people which result from such problems” (Cameron, 2006 p292). Simply signposting to health professionals when childhood obesity is raised in strategic or locality-based based consultations could be seen as assenting to the biomedical dominance of how well-being and health should be defined and addressed. EPs need to take seriously the relevance of childhood obesity as a challenge to espoused professional commitment toward anti-oppressive practice with children and young people with medicalised identities (Aphramor, 2008).

In summary, Davis-Coelho and colleagues state (2000 p638) “As a discipline, psychology can serve to reinforce the oppression of some members of society, or it can serve to combat such oppression. Only through the individual efforts of its members can the field of psychology begin to empower fat people, rather than contribute to their oppression”.

On a personal professional level, this study has been a significant first step in my own endeavours as an EP to come forward, explore and attempt to define my own position in taking up this challenge within a research and practice arena.